JUNE 1958

THE DRIVE FOR EXPLORATION

THE NEED FOR HUMAN ACCEPTANCE

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Mental Hospitals

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References
1. Flipse, M. J.: Clin. Med. 4:1237 (Oct.) 1957. 2. Hutchinson, J. T.: Paper presented, American Psychiatric Association, Philadelphia, Pa., Nov. 17, 1956. 3. Sarwer-Foner, G. J., and Koranyi, E. K.: Canad. M. A. J. 77:450 (Sept. 1) 1957.

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THIS MONTH'S COVER

THE "ALL FAITHS CHAPEL" at Hastings State Hospital, Nebraska, is a stirring example of the current move to bring the community and the hospital together. Built on the grounds of the hospital by subscription from the community, the chapel is the result of a joint effort which was sparked in 1950 by the local ministry and the hospital administration, when patients objected to the recreational department of the hospital as their only place for worship.

The original citizens' committee for the proje was under the co-chairmanship of a minister an an attorney, and included among its 40 member the Governor of Nebraska and the members of the State Board of Control. Although most of the money contributed came from the 53 counties served by the hospital, funds were received from sources in 21 states and the District of Columbia, and over $7,000 came from sections of Nebraska outside the hospital area. Hospital staff members served on the committee but did not direct the project.

Patient interest mounted as the project grew. One patient brought flowers to the chapel site from the time the ground was broken until the project was completed; another, who assisted the Chaplain, handled approximately 120,000 pieces of outgoing and incoming mail. Vestments, bibles, choir robes and altar appointments were gifts from various community agencies. The local union of hospital employees, with the help of other personnel and of patients, provided the funds for a beautiful organ with chimes, and there is a sustained program underway to furnish the chapel with stained glass windows as memorials. Even the landscaping was in part a gift, the remainder coming from hospital nursery stock.

The over-all exterior size of the building is 50 feet 8 inches wide by 110 feet long. The height, including the aluminum skinned spire, is 72 feet. The nave is 46′ 8″ wide by 71′ 2″ long; the height from the floor to the ceiling at the center is 43 feet. The nave accommodates 360 persons seated in pews, and in addition, space is provided for 12 patients in wheel chairs, the organ, and a choir of 20, making the total capacity 392. A 300-foot tunnel from the basement connects the chapel to the tunnel system between other buildings of the hospital. The total cost, not including tunnel, plumbing, heating, electrical or ventilating work was $97,098.90.

Appropriately, the Chapel was dedicated on two occasions. The first was for the patients; the second, on April 28, 1957, was for the public. Since that time regular services have been held for patients of all faiths in this living monument on the grounds of a state hospital—a symbol that the community cares.

JACK A. WOLFORD, M.D.
Superintendent

New Medical Director Appointed

ON BEHALF OF the Council of the American Psychiatric Association, President Francis J. Gerty announces the appointment of Dr. Matthew Ross (right) of Beverly Hills, California, to succeed Dr. Daniel Blain as A.P.A. Medical Director, effective September 1, this year.

Dr. Ross, 41, is a native of Massachusetts. He graduated from Tufts Medical School in Boston in 1942 and took his residency training at the Brentwood Veterans Administration Hospital in California. He also had three years of specialist training with the Los Angeles Psychoanalytic Institute. He became a Diplomate of the American Board of Psychiatry and Neurology in 1950.

In World War II, Dr. Ross served as a Major in the Army Medical Corps in the European Theatre where, in Switzerland, he met his wife Brenda, who was a Major in the U. S. Army Medical Administrative Corps. Married in 1946, they have four children, Douglas, Gail, Craig and Bruce.

Dr. Ross has been a Member of A.P.A. since 1948 and a Fellow since 1953. He has served on the Nominating Committee and the Committee on Membership. He was Speaker of the District Branch Assembly in 1956-57. He is also a member of the Committee on College Students of the Group for the Advancement of Psychiatry.

He is Assistant Clinical Professor of Psychiatry and and also of Psychology at the University of California Los Angeles Medical Center. He has been in private practice in Los Angeles and has also served as Attending Psychiatrist at the U.C.L.A. Medical Center, Mt. Sinai Hospital, Compton Sanitarium and at other hospitals.

Dr. Daniel Blain,
Retiring Medical Director

Dr. Matthew Ross

New A.P.A. Officers Installed

Dr. Francis J. Gerty, Professor and Chairman of the Department of Psychiatry, University of Illinois College of Medicine, Chicago, succeeded *Dr. Harry C. Solomon,* Superintendent of the Massachusetts Mental Health Center, Boston, as President of the American Psychiatric Association, on May 16th.

The new Secretary of the Association is *Dr. C. H. Hardin Branch,* Professor and Chairman of the Department of Psychiatry, University of Utah School of Medicine, Salt Lake City, succeeding *Dr. William Malamud,* Professor and Chairman of the Department of Psychiatry, Boston University School of Medicine, who becomes the President-Elect, succeeding *Dr. Jack Ewalt,* Commissioner of Mental Health, Massachusetts, as Treasurer is *Dr. Robert H. Felix,* Director of the National Institute of Mental Health, U. S. Public Health Service.

Two Vice-Presidents were elected: *Dr. William B. Terhune,* Medical Director of the Silver Hill Foundation, New Canaan, Conn., and *Dr. David C. Wilson,* Professor of Psychiatry and Neurology at the University of Virginia School of Medicine, Charlottesville.

Three new Councilors were elected to three-year terms: *Dr. Dana L. Farnsworth,* Director of University Health Services, Harvard University and Radcliffe College, Cambridge, Mass.; *Dr. Robert T. Morse,* Associate Professor of Clinical Psychiatry, Georgetown University Medical School, Washington, D. C.; and *Dr. Lawrence C. Kolb,* Director of the N.Y. State Psychiatric Institute, and Professor and Chairman of the Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York City.

PROFESSIONAL
Feature
Of The Month

THE NEEDS OF MENTAL PATIENTS

VI. The Drive for Exploration

By BRIAN BIRD, M.D.
Associate Professor of Psychiatry
Western Reserve University, Cleveland, Ohio

SOME PEOPLE climb mountains. Others head for the South Pole. People who do this are explorers. But they are not the only ones. Everyone, whether he knows it or not, is an explorer.

The man turning the pages of his morning paper, the child watching television, the woman calling on her neighbor—they are all exploring something or other, and it goes on all day long in almost everything we humans do.

Studying and learning, searching and finding, whether at work or at play, are all essentially exploratory. So is the appeal of new friends and new interests; in fact, newness of all kinds. Exploratory activities tend to be exciting, and nearly all are interesting and rewarding. They are usually fun, too.

Yet the main goal of exploring is none of these. Exploring's main goal, dull as it may sound, is simply to relieve the tension of not knowing. Like all drives, this drive arises out of tension, and its aim is to reduce that tension. Exploration's drive arises when a person is confronted with something he doesn't know, and the drive is satisfied by trying to make that unknown known.

Strictly speaking, therefore, there is really no such thing as a drive for exploration. The drive is not to find newness, but oldness; not to discover strangeness, but to convert strangeness into familiarity. Unable to stand the tension of not knowing, a person is driven to explore whatever it is he does not know. And he goes on exploring until familiarity relieves the tension. Familiarity always does away with the drive—perhaps only temporarily until still other unknown factors appear—but by definition it is obvious that one cannot explore the familiar.

The idea that exploration is a reaction to the unknown is rather important. For one thing, it helps explain how and why certain people give up exploring. For another, it helps in trying to devise ways and means of preserving it and reviving it.

The possibility that exploration would ever be willfully given up seems very strange. Yet it often is. And apart from those cases where disease knocks the instinct out, the giving up of exploration is nearly always a deliberate although unconscious act. Exploration, involving as it does a poking around in the unknown, is always a risky business. This is why, if it seems too risky, a person may have to call a halt to it.

For most people, halting exploration is surprisingly easy. No direct struggle with the instinct is necessary. All that has to be done is to isolate the instinct, i.e., to make sure it never receives any stimulation. And all that is needed for that is to see that nothing unknown gets left around in the open. This, too, is easy to do. Some persons do it merely by assuming they already know everything. Once one is convinced he knows everything, he is safe from exploration. There is simply nothing left to explore.

Others create the same effect by literally surrounding themselves with familiarity. They dig a deep rut and live their lives in it. They organize their day, their week, their year in such a way as to exclude all surprises, changes, newness, spontaneity and imagination. They include in their life only well-established custom, routine, sameness and familiarity. Life in a rut is immune to exploration—literally nothing shows up to be explored.

Mentally Ill Avoid the Unknown

Living in a rut is not, of course, all bad. How normal it is, in fact, to pull one's horizons in closer and closer, especially as one grows older and more set in his ways. But normally, horizons should be pulled in only enough to avoid unnecessary, unending or fruitless exploratory activity.

It becomes definitely abnormal when the unknown is avoided simply because it is unknown. And this is precisely what happens in the case of various mental disorders. Most such disorders, in fact, have, as part of their symptomatology, mechanisms with the specific purpose of curtailing exploratory activity.

In the case of obsessive-compulsives, their ever-increasing rigidity and intellectualization very severely limit excursions into the unknown.

In the case of phobics, their attacks of anxiety and resulting physical restrictions materially impair spontaneous explorations.

In hysterics, their marked denial and repression shut off from consciousness and from action so many "unknowns" that the temptation to explore is largely lost.

In depressives, it is obvious how seriously exploratory drives are impaired. Even in mania, which overtly seems so searching, true exploration is not possible.

In schizophrenia, of course, exploration is grossly affected. In the psychotic parts of the schizophrenic patient, exploration is completely divorced from reality; and in the non-psychotic parts, it is severely disturbed.

In practically all these disorders, inhibition of exploration occurs chiefly because the unknown contains too many personal dangers. These personal dangers are just that—personal, individual, unique. They are not "real". At least they are not like the real danger of being blown to bits while exploring the properties of an unknown chemical, or being eaten by a tiger while exploring an unknown forest, or falling down a strange mountain. Yet the reaction to such real dangers is no stronger than to many seemingly nonexistent personal dangers. After all, danger is danger, and has only one criterion: the person regards it as dangerous.

Let me give what may seem an absurd example of personal danger. A patient of mine who in most ways was very brave was terribly afraid of the unknown. He took part freely in many overtly dangerous activities, yet he literally could not do such a completely harmless thing as listen to broadcast news, nor could he read an unknown novel. In both cases he was terrified of what might transpire.

Now, many people dislike listening to the news and will shut off the TV when it comes on. And many people will peek at the back of a novel before they decide to read it. If this is the extent of their avoiding the unknown, no great harm is done—there are quite a few novels one can get along without reading!

But when this process extends, as it does in all mental disorders, it becomes a matter of great therapeutic importance to reverse the trend and to bring back a patient's urge to explore. In trying to revive exploration, success is much more likely if full consideration is given to the stimulating effect of "not knowing". It may be possible, of course, to stimulate a patient's exploration simply by pointing out all the wonders of the world around him, or by telling him that exploration will make him well and happy, or that he will be rewarded in some other way by exploring.

But the chances are, this will not be enough. What may be needed is the creation in him of a proper state of functional tension. The proper tension for this purpose is one that presents to the patient a tantalizing but not frightening picture of the unknown. It is something like teasing a patient by saying, "I know something I won't tell". The object is not only to interest the patient but to activate him, to start him scratching away on his own.

Irritation of Not Knowing Is Valuable Stimulus

The unknown must not be explored *for* him. It must be dangled in plain view, but just out of his grasp. Not out of his reach, however. It must be within his means to explore and to solve. An unsolvable puzzle is not stimulating, nor is one too easily solved. What is needed is the tension of not knowing, the irritation of not knowing, coupled with the nagging suspicion that a little exploring will clear it up. Those are the ingredients of a proper stimulus.

Presenting such a stimulus, however, may not be easy, especially to neurotic and psychotic patients. Stimuli are essentially intrusions, and patients are well defended against intrusions. That is what their illness is for. So there is often little use presenting anything passively. A much more active approach may be needed; i.e., somehow their attention must be literally taken hold of. In effect, what has to be done is to shove them off base, to rock the boat, to pull the rug out, to upset their equilibrium, to break up their rut, to burst their cocoon.

Upon first hearing, this kind of approach sounds cruel and is a far cry from the care of patients that centers around comfort, security, and freedom from irritation. In fact, the two seem at opposite poles. And they are. But both may be proper, since each has different applications. Certain patients, for instance, should not be stimulated, should not be expected to revive active interests; for them, comfort and protection should be the aim. Also there are patients who, in order to be able to find the courage to attack the unknown, require a great deal of preliminary comfort and support.

But with patients who are sinking deeper and deeper into a stimulus-free rut, more than love and comfort may be needed to get them out. Specifically, they may need help which in essence is actively irritating and disturbing. To give it a name, what they need might be called "judicious uprooting".

Unfamiliarity Breeds Exploration

The benefit of such uprooting is often seen as an incidental effect when patients are moved from one hospital ward to another. Once in my experience, architectural change made it necessary for me to move a whole group of patients. Soon after the change was made, a few of the most disturbed, destructive and withdrawn patients improved quite remarkably. This kind of observation has been made so often as to suggest that transferring patients should become a regular part of hospital procedure. Traditionally, patients are recommended for transfer only when their condition changes; i.e., if they improve, they go to a better ward; if they become worse, they go to a more closely supervised ward; those who do not change tend to remain where they are.

Using a different rule, one might pick out for transfer precisely those patients who do not change. It could be argued that the reason they do not change is that having become thoroughly familiar with their surroundings, they no longer receive any exploratory stimuli. Theoretically, therefore, a transfer would help. On another ward, unfamiliarity would force itself on them; thereupon they would bestir themselves to explore that unfamiliarity, and in the process revive some normal part of themselves.

Aside from transferring them, however, introducing therapeutic strangeness into patients' lives is often very difficult. In many hospitals it may be doubly difficult: added to the problem of patient inertia is a deadly inertia set up by the hospital itself. All the rules, regulations and routine, so necessary for hospital efficiency, have the unfortunate effect of sinking patients deeper into the very ruts their illness has dug for them. The plain fact is that hospital life, as it is so often set up, is aimed directly at eliminating strangeness, spontaneity

and variety, the very things so necessary to stimulate the drive for exploration.

This is why, in introducing strangeness to hospitalized patients, it is not only patient-resistance that must be overcome but hospital-resistance as well.

This latter is not easy. After all, hospitals do run best when routine is fixed and changes are few. Hospital life really is much simpler when patients routinely eat, sleep, and spend their day in the same place. And patient management is easier when patients are marched in groups to meals, to work, to shows, to dentistry, to X-ray. And efficiency is greater when all haircutting is done every third Thursday a.m., shaving on Mondays and Saturdays, and bathing on Fridays. It is true, too, that patient-disturbances can be reduced by strict regulation of visitors, correspondence, and personal freedom, and by toning down movies, church services and recreation. And patients really do tend to be more controlled when their life is directed by the same staff day in and day out.

Taken altogether, the establishment in a hospital of a familiar, never-changing routine is like wearing an old shoe. It is comfortable, and there are no pressures, twingings or pinchings. And it is cheap. But like an old shoe, it is not always healthy.

In some hospitals this trend is carried to a point where a kind of moral premium is placed upon serenity: a disturbed patient is regarded as a staff failure, whereas a quiet patient, no matter how sick, although not regarded as a success, is at least not held against the staff.

Hospital Routine Digs Ruts for Staff and Patients

There seems to be only one possible exception to the maxim that what is good for the hospital is not good for the patient. That is the truly hopeless patient. In his case, what is best for the hospital is perhaps best for him. Perhaps he should be kept quiet, undisturbed and free from all stimuli. But for the rest of the patients, all those for whom any hope exists, just the reverse is true. With them, every effort should be made to see that hospital routine does not bury them deeper in an already self-imposed rut of routine and familiarity.

And there is really only one fairly good way of doing this: by judiciously uprooting the staff from time to time. Good intentions are not enough; the establishing of rules and regulations to counteract the stultifying effect of rules and regulations is not enough. The only thing that will offset routine—if it is important to offset it—is to upset it.

In all organizations, mental hospitals included, certain staff members tend to hold one job for life. In many jobs this is highly desirable, and people who achieve such long records can be justifiably proud. But in the area of patient-care, perpetual tenure should always be carefully watched lest it lead to a warding off of newness, change and spontaneity.

On chronic services especially, personnel, faced with unchanging patients and fixed routines, tend to lose their exploratory drives. Almost the only way to prevent this is to shift people around occasionally in their jobs. Judicious uprooting, confronting personnel as it does with strangeness and unfamiliarity, stimulates their all-important drive to question, to search and to explore.

An experience of my own may illustrate this uprooting effect. What happened to me was that I was suddenly uprooted from a nice familiar job on an active treatment service and shifted, much against my will, to an unfamiliar chronic service.

For the first few months my new job was surprisingly easy. The service was so well organized that practically all I had to do was make rounds. These rounds consisted of walking through one ward after another at just the right speed. The right speed, I discovered, was very important! If I walked too fast through a ward, the head nurse would feel I was neglecting her; if too slow, she would suspect I was dissatisfied.

I learned also that it contributed to serenity to follow the suggestions of the head nurses. They always seemed to know what I should do and, in fact, laid out most of my decisions for me. For instance, if a patient had an illness or an injury, the head nurse would certainly draw my attention to it, and almost certainly would add a polite hint about the proper treatment. And if a patient was ready for a change in routine, I could rely on the head nurse to suggest it to me. So I had it very easy.

Patients Unknown Quantity to Staff

Only one thing bothered me: I knew almost nothing about my service. This was not bothersome as long as I was not aware of not knowing. But one day I was forced to face it. On my desk was a list of names of all my patients. I was surprised at how long the list was—pages and pages of names. I was surprised, too, that most of the names were strange to me.

Curious, I sat down and added up all the names—seven hundred and fifty. Then I added up the ones I knew—fifty. So there it was: the inescapable fact that I did not know seven hundred patients. This was intolerable. Not knowing these patients was just as unbearable to me as it must be to a mountain climber to see a mountain he does not know. And the challenge was the same. Just as the mountain climber must explore the unknown mountain, so I had to explore these unknown patients.

And I did. I set out to know every one of them. The job was not easy. The first hindrance was the similarity of the patients. Dozens of them looked all alike to me—with their cropped hair, bare feet, institutional dresses, all huddled together on benches. But this exploratory difficulty made the job even more imperative. I simply worked harder seeking out whatever small identifying differences there might be.

A second difficulty was that the nurses themselves did not know many of the patients. They thought they did—but when I asked who the lady in the corner was and they weren't sure whether she was Jane Doe or Joan Roe, their own ignorance shocked them. This difficulty, however, proved to be very stimulating. Challenged by what they did not know, the nurses themselves began exploring their patients anew. Now their minds, as well as mine, were filled with questions. Not just about names and faces, but about everything.

For example, they became curious about patients' ages. This began one day when they guessed a certain patient's age at "about 30". They were all shocked, but

challenged as well, to learn from the file that this patient had been in the hospital for over 30 years and was well past 60.

Another challenge was the discovery that none of the nurses quite knew why a group of forty women patients was on full bed care. They had vague recollections that this patient had had a coronary and that patient a stroke, another a fractured hip, and several had had "weak spells". But no one knew just when these illnesses had occurred or just why these patients were still in bed. The only possible explanation seemed to be that no one had ever questioned their being in bed. Their bed care had simply become a familiar routine which no one ever challenged. Once challenged, it became the immediate concern of everyone. The result was that most of the patients were quickly back on their feet and very much better for it.

This type of exploration was extremely contagious and rapidly spread in every direction. I was able finally even to raise questions about the rigidity of ward rounds! Sooner or later almost everything came under scrutiny. The only stimulus needed was to keep my own eyes open to the unknown and to encourage the staff to keep their eyes open, too. Once we saw what we did not know, the drive for exploration took over and did the rest.

And it all began just because an astute medical superintendent had had the good sense to uproot me from a comfortably familiar job and to send me unceremoniously into a job so unfamiliar that its very strangeness pushed me into all kinds of helpful explorations.

VII. The Need for Human Acceptance*

By CARL A. L. BINGER, M.D.

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Member Board of Consultation, the Massachusetts General Hospital,
Editor-in-Chief, Psychosomatic Medicine

THERE IS A STORY about a general store in Vermont. A farmer came in to buy some supplies and he greeted the storekeeper with a "Howdy, Si?" There was no answer, so he repeated his greeting. Again no answer. Then he said, "Good morning, Si. How's things to-day?" To this the storekeeper replied: "It's none of your Gawd damn business, and if you warn't a friend of mine I wouldn't tell you that much!"

Perhaps this is the way some of our studied silences impress our patients. But we have other ways of avoiding a relationship with them. These vary from the stiff, humorless mannerisms of a petty official, or the cool disdain of a traffic cop who has just handed us a ticket, to a preoccupation with the written record or case history rather than with the person himself. Many of our young residents hide their own self-consciousness and ineptitude behind a cloud of ink, like startled and diffident cuttlefish. But our patients' needs are insistent. If the walls of some of our mental hospitals could speak, they would echo the words of Richard III: "Now is the winter of our discontent"; or of Jeremiah:"Is there no balm in Gilead? is there no physician there?" This is the cry from the bereft, the despairing, and the abandoned; and that is how many of our patients feel—both alien and alienated. Their need is to feel human again and accepted. I shall assume throughout this article—though this may be a bold assumption—that the basic needs for shelter, warmth, food, and clothing—yes, even for cleanliness, decency and kindness—are provided for. But these alone are not sufficient. Most patients who consult psychiatrists, and especially those who have to be hospitalized, have been through a crisis of some kind, and during this crisis two changes have occurred in them. One is an awareness—sometimes painfully sharp, at other times, vague, ominous, cataclysmic—that something strange is going on inside them and the other is a realization that people—their loved ones, their friends and familiars—are somehow acting differently toward them. These two experiences are bewildering and frightening. They prompt some patients to accept readily the help offered them and even to enter a hospital, if that seems necessary.

But others are driven to more intense fear and bewilderment by our ministrations, and appear to want only to thwart us. We say that the first group has insight and the second group lacks it, but this is not always a valid or fixed distinction. Insight is a variable and fluctuating property of the mind.

In order to help our patients feel human again, we must be able to communicate with them. This is often a difficult matter to achieve, especially if they are, as we say, inaccessible. Accessibility can sometimes be facilitated by electro-convulsive treatment or by the use of insulin or one of the so-called "ataractic" drugs. Once won, even if only partially, it must be utilized for communication, i.e., for a relationship. Because only through a relationship with another will the disturbed patient be able to recapture and hold on to his lost identity—

* *In Dr. Barton's paper, "Expressions of Human Needs" published in MENTAL HOSPITALS, December 1957, this area of the topic "The Needs of Mental Patients" was discussed briefly under the headings "The Need Expressed toward being a Part of Something Larger than One's Self" and "Need for Recognition, Approval, Positive Response."*

to what has been called his "constant and predictable personality"—so that he can say again: "This is me."

But how is the psychiatrist to uphold his end—to make communication possible and workable? There are no rules to help him, no Berlitz courses or linguaphone records to provide him with key words. Here, feeling and sensitivity are more important than syntax and semantics. Some doctors have the gift in high degree, others have relatively little of it and still others can be taught by experience and emulation. Perhaps it is like the possession of absolute pitch and the training of one's ear for music. Adolf Meyer had this gift with his dark, high-powered headlight eyes and Tom Salmon with his great simplicity and integrity. And Bleuler must have had it, too. He was once asked by one of his assistants how he had managed so well with a certain schizophrenic patient. Bleuler is said to have answered: "The patient cried and I cried. Then he laughed and I laughed, and then he got well." Of course, there was more to it than that. Good feelings and sound intuitions are not enough without learning and analytical ability and the capacity to deal with abstractions. We need them all for understanding and we need understanding in order to communicate with our patients. By communication, we establish a relationship and in this relationship they find themselves and come alive again.

Having said this, I have perhaps said all I can about the needs of mental patients. They are, after all, an abstraction. Without knowing something of their idiosyncratic peculiarities one cannot write a general prescription for them or a job specification. One would not urge the young Van Gogh to join the Boy Scouts. We need more information than is contained in a list of impulses or primitive drives or even of their "economic" distribution. A chair ceases to be a chair and we can have no workable relationship with it if we describe it only in terms of the molecular structure of the wood that it is made of—or perhaps even as a knockdown assembly of parts. In the case of our patients we must learn something of their value systems, what they cherish, what they habitually feel to be important, whether this is the result of their personal experiences or the conventions of their group. For example, what does privacy mean to them, or gregariousness, or companionship? How much does their self-esteem depend upon praise or worldly success? Do they live in the past, in the present, or in the future?

Even such facts we shall not come by except by the thawing action of a relationship. To try to re-establish in the patient what Erikson calls "basic trust" seems to be our primary task. Without this nothing much can be ventured in life.

Counter-Transference Seldom Discussed

Can one say anything meaningful about the mystery of relationship? It has been dealt with chiefly in terms of the so-called "transference" which Freud first described in 1895. Astonishingly little has been added to his original concept. And as for its obverse—the counter-transference relationship—this is the neglected stepchild of psychiatric literature. In 1910 Freud wrote: "Other innovations in technique relate to the physician himself. We have become aware of the counter-transference, which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it." I think that one has a right to add: overcome the neurotic, unrealistic, displaced parts of one's feelings, and not by forgetting them or suppressing them but by confrontation. Genuine feelings cannot be overcome, nor, in my opinion, should they be. Five years later in a paper called "Transference-Love" Freud wrote: ". . . the psychoanalytic treatment is founded on truthfulness. A great part of its educative effect and its ethical value lies in this very fact. It is dangerous to depart from this sure foundation."

To confront one's feelings and fantasies with honesty and courage is not easy for the best analyzed analyst, nor for the seasoned, experienced psychiatrist whose days are spent busily removing the beams from other people's eyes. He is often too driven, too encumbered with routine duties or with personal ambition to be greatly concerned about his own motes. And so the counter-transference is seldom openly discussed, because it is a private and delicate matter. When teachers of young psychiatrists refer to it they often do so in a slightly minatory manner, as if it were rather unseemly, like halitosis.

Psychiatrist's Reactions Need Scrutiny

But the psychiatrist's feelings and reactions need illumination and scrutiny. Here lies a path not only to understanding his own functions as a therapist but also to meeting some of the needs of his patients, though no psychiatrist alone can meet them all. One can get more than a leading light from the words of the philosopher, Martin Buber. Though he may be difficult to read at first, after one's ear becomes attuned to the poetry and majesty of his prose it begins to come clear. I shall end with this quotation from him:

> ". . . For the inmost growth of the self is not accomplished, as people like to suppose today, in man's relation to himself, but in the relation between the one and the other, between men, that is, pre-eminently in the mutuality of the making present—in the making present of another self and in the knowledge that one is made present in his own self by the other—together with the mutuality of acceptance, of affirmation and confirmation.
>
> "Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other. The human person needs confirmation, because man as man needs it. An animal does not need to be confirmed, for it is what it is, unquestionably. It is different with man: sent forth from the natural domain of species into the hazard of the solitary category, surrounded by the air of a chaos which came into being with him, secretly and bashfully he watches for a Yes which allows him to be and which can come to him only from one human person to another. It is from one man to another that the heavenly bread of self-being is passed."

PASTORAL WORKSHOPS TEACH PSYCHIATRIC CONCEPTS

By Rev. ALEXIUS PORTZ, O.S.B., Director
Institute for Mental Health, St. John's University, Collegeville, Minnesota

NEARLY 500 clergymen of all faiths have participated in the summer workshops of the Institute for Mental Health of St. John's University over the past four years. Although some clinically trained chaplains attend, the sessions are primarily intended for pastors and chaplains in parish, school and general hospital.

To a man dedicated to the proposition that religion serves a major function in life, the welter of panaceas to relieve mental illness—especially, perhaps, psychoanalysis—may seem threatening. The extreme claims made for drugs—"happiness pills" according to the popular press—arouse defenses, and he sometimes feels a real reluctance to get involved in the problems of mental illness, even when they affect his parishioners. The opposite reaction also exists where a priest or pastor unwisely rushes in with a "moralizing" approach.

Moreover, as an optimistic American with a corresponding self-image, the pastor finds it hard to tolerate failure. When a parishioner who is mentally ill comes to his attention, his spontaneous reaction may be to ignore the situation, to avoid the threat of possible failure.

St. John's pastoral psychology workshops are a modest effort to involve the pastor more fully in community mental health problems by preparing him to understand the mentally ill, to become more emotionally at ease with people in distress, to learn some of the procedures of referral, and in the end to become more confident about the constructive role he can play in dealing with the mentally ill.

As a pilot-study project, the workshops help to formulate methods by which clergymen and the psychiatric profession can best work together in helping people suffering from mental stress. A few of the mental hospital chaplains who have participated have told us that they previously felt they were only acquainted with hospital procedures, and lacked a really satisfying and mutually understood relationship with other staff members. If this is true in the inner sanctum—the hospital—how much more so for clergy of the receiving area, the community?

The workshops themselves are planned, therefore, not so much as an academic learning experience but as an opportunity for clergymen to discuss problems and approaches in mental health with some of the best-qualified psychiatrists in the country. A large and experienced faculty is made possible through annual grants by the Hamm Foundation of St. Paul. The Institute's planning committee thinks of the annual summer workshops as orientation sessions in which attitudes are developed rather than information imparted.

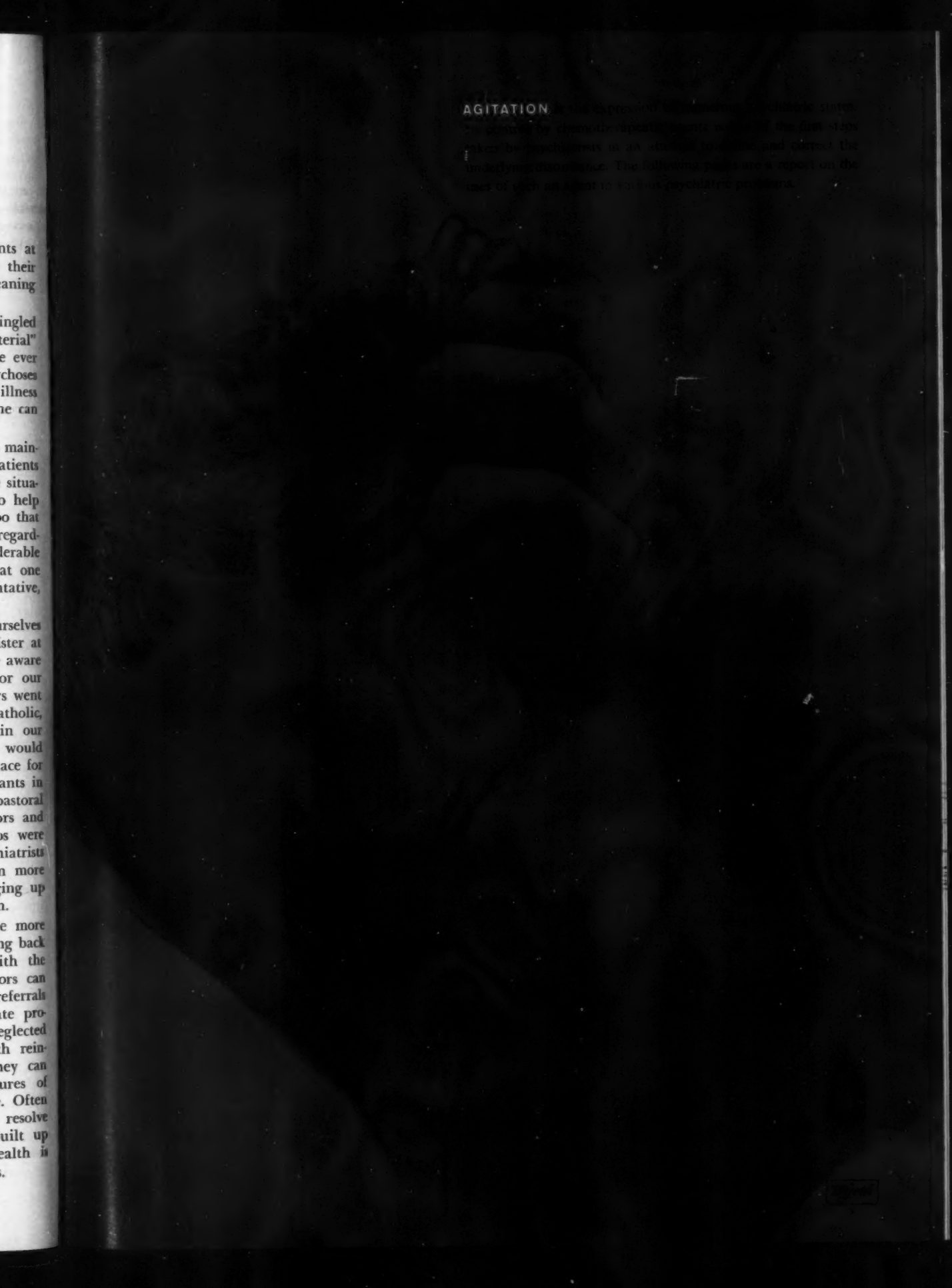
The give-and-take of intimate dialogue between clergymen and faculty is exploited to the hilt. A full-time faculty of six, predominantly psychiatrists, live a 16-hour day with the forty clergymen participants at each week-long session. These men illustrate by their attitudes, more than by verbal teaching, the real meaning of acceptance of the person in distress.

The pastor's skills in relationships may be singled out as the element stressed most in the "content material" of the workshops. The pastor's skills—whether he ever learns the theory sufficiently to catalog the psychoses does not matter—will help nip developing mental illness in the bud. There will be fewer breakdowns if he can give support when it counts most.

The pastor comes to realize the importance of maintaining a relationship with hospitalized mental patients despite his former feelings of helplessness in these situations. He now knows that he may be unable to help the patient in any obvious way. But he knows too that a genuine "hello" and demonstrated acceptance, regardless of the patient's response, can have a considerable effect on recovery. The patient thereby finds that one relationship, that with God through His representative, is still intact.

"We are a little better able to understand ourselves through this experience together" said one minister at the end of his workshop. "We have become more aware of the possibilities we have within ourselves for our work with people. And we found as the seminars went along that each of us, whether Protestant or Catholic, could exchange suggestions that were helpful in our dealings with people. It was not an easy week. I would not recommend it to my colleagues as a good place for an inexpensive vacation." A few of the participants in St. John's workshops have gone on for clinical pastoral training. The vast majority, however, are pastors and chaplains and teachers for whom the workshops were an opportunity to discover firsthand how psychiatrists really think and operate. This had made them more receptive to the orientation courses now springing up all over the country for community clergymen.

The intensive workshop helps pastors become more able to give spontaneous support instead of falling back on gimmicks and clichés in their contacts with the mentally ill and their families. Informed pastors can prevent the brutal trickery sometimes used in referrals to mental hospitals and they can help motivate prospective patients. They find the all-too-often neglected opportunities for assisting former patients with reintegration into the community. Best of all, they can carry out the more remote preventive measures of helping couples prepare for healthy family life. Often too, through counseling, they assist people to resolve problems before unmanageable defenses are built up which eventuate in breakdown. If mental health is everybody's business, it is *a fortiori* the pastor's.


AGITATION

DRUG ADDICTION. Response to SPARINE: Rapid control (in 24 hours) of agitation, nausea, vomiting, muscle and joint pains, abdominal cramps, and general malaise—withdrawal symptoms of drug addiction.

AGITATION IMPEDING PSYCHOTHERAPY. When first seen, this patient was markedly agitated and destructively aggressive. Her excitation was a barrier to psychotherapy. Response to SPARINE: The hyperactivity gave way quickly to emotional calm, and rapport became established.

DELIRIUM TREMENS. This patient has a long history of alcoholism. When police brought her in, she was suffering from the postalcoholic syndrome. Response to SPARINE: The overactivity, acute hallucinosis, tremulousness, and nausea were controlled overnight. Upon discharge, the patient reported an easier recovery than ever before.

ADVT.

SENILE AGITATION. This is a nursing-home patient with cerebral arteriosclerosis. Like many such patients, she was hostile, assaultive, acutely restless, and untidy. Response to SPARINE: She quickly became calm, relaxed, and improved in interpersonal relationships. She has resumed a normal interest in personal hygiene and appearance.

MANIC PSYCHOSIS. On admission to the psychiatric hospital, this patient was "high," combative, and hallucinating. Response to SPARINE: The violent psychomotor activity was promptly subdued; the belligerence was eliminated; and the hallucinations were less disturbing. The patient then became accessible.

BEHAVIOR DISORDERS OF YOUTH. The boy in the foreground was committed as a behavior problem, with police and school records of sustained incorrigibility. Response to SPARINE: Agitation and belligerence controlled, behavior improved. He is responding now to psychotherapy and rehabilitation.

Central Inspection Board Issues "Approved" Listing

IN ORDER TO clarify the present status of hospitals *approved* by the A.P.A. Central Inspection Board, as distinct from hospitals *accredited* by the Joint Commission on Accreditation of Hospitals, the Central Inspection Board has authorized the publication of the following list of hospitals, each of which has been *inspected* and *approved* or *conditionally approved by the A.P.A.*

Approved:

Fairfield State Hospital, Newton, Conn.
Connecticut State Hospital, Middletown, Conn.
Norwich State Hospital, Norwich, Conn.
Galesburg State Research Hospital, Galesburg, Ill.
Spring Grove State Hospital, Catonsville, Md.
Boston State Hospital, Boston, Mass.
Metropolitan State Hospital, Waltham, Mass.
Worcester State Hospital, Worcester, Mass.
Northville State Hospital, Northville, Mich.
New Hampshire State Hospital, Concord, N. H.
Danville State Hospital, Danville, Pa.
Mayview State Hospital, Mayview, Pa.
Norristown State Hospital, Norristown, Pa.
U. S. Public Health Service Hospital, Lexington, Ky.
Veterans Administration Hospital, Sepulveda, Cal.
Veterans Administration Hospital, Brockton, Mass.
Veterans Administration Hospital, Montrose, N. Y.
Veterans Administration Hospital, Salisbury, N. C.
Veterans Administration Hospital, Pittsburgh, Pa.
Veterans Administration Hospital, Fort Meade, S. D.
Veterans Administration Hospital, Salt Lake City

Private Hospitals:

Institute of Living, Hartford, Conn.
North Shore Health Resort, Winnetka, Ill.
C. F. Menninger Hospital, Topeka, Kansas
Cedarcroft Sanitarium, Silver Spring, Md.
Sheppard & Enoch Pratt Hospital, Towson, Md.
McLean Hospital, Waverley, Mass.
Ring Sanatorium, Arlington Heights, Mass.

Approved conditionally:

Arizona State Hospital, Phoenix, Ariz.
Agnews State Hospital, Agnew, Cal.
Camarillo State Hospital, Camarillo, Cal.
Metropolitan State Hospital, Norwalk, Cal.
Napa State Hospital, Imola, Cal.
Patton State Hospital, Patton, Cal.
Stockton State Hospital, Stockton, Cal.
Chicago State Hospital, Chicago, Ill.
Kankakee State Hospital, Kankakee, Ill.
Manteno State Hospital, Manteno, Ill.
Woodmere State Hospital, Evansville, Ind.
Topeka State Hospital, Topeka, Kansas
Augusta State Hospital, Augusta, Me.
Springfield State Hospital, Sykesville, Md.
Danvers State Hospital, Hathorne, Mass.
Foxboro State Hospital, Foxboro, Mass.
Gardner State Hospital, Gardner, Mass.
Grafton State Hospital, North Grafton, Mass.
Medfield State Hospital, Medfield, Mass.
Northampton State Hospital, Northampton, Mass.
Taunton State Hospital, Taunton, Mass.
Westboro State Hospital, Westboro, Mass.
Pontiac State Hospital, Pontiac, Mich.
Traverse City State Hospital, Traverse City, Mich.
Ypsilanti State Hospital, Ypsilanti, Mich.
St. Louis State Hospital, St. Louis, Mo.
Hastings State Hospital, Ingleside, Neb.
New Jersey State Hospital, Greystone Park, N. J.
New Jersey State Hospital, Marlboro, N. J.
New Jersey State Hospital, Trenton, N. J.
Oregon State Hospital, Salem, Ore.
Harrisburg State Hospital, Harrisburg, Pa.
Philadelphia State Hospital, Philadelphia, Pa.
Warren State Hospital, Warren, Pa.
Woodville State Hospital, Woodville, Pa.
State Hospital for Mental Diseases, Howard, R. I.
Austin State Hospital, Austin, Tex.
Terrell State Hospital, Terrell, Tex.
Eastern State Hospital, Williamsburg, Va.
Western State Hospital, Ft. Steilacoom, Wash.
Provincial Mental Hospital, Essondale, B. C., Canada
Territorial Hospital, Kaneohe, Hawaii
U. S. Public Health Service Hospital, Ft. Worth, Tex.

Private Hospitals:

Emory John Brady Hospital, Colorado Springs, Colo.
Fairview Sanitarium, Chicago, Ill.
Our Lady of Peace Hospital, Louisville, Ky.
Chestnut Lodge, Rockville, Md.
Seton Institute, Baltimore, Md.
Bournewood, Brookline, Mass.
Harworth Hospital, Detroit, Mich.
Ingleside Hospital, Cleveland, Ohio
Morningside Hospital, Portland, Ore.
Oak Ridge Sanitarium, Austin, Tex.
Owen Clinic, Huntington, W. Va.
St. Mary's Hill, Milwaukee, Wis.
Institute Albert Prevost, Montreal, Quebec, Canada

In 1956 the Joint Commission stopped using the terms "conditionally" or "provisionally accredited" and substituted the term "accredited for one year". Hospitals

accredited by the Joint Commission for one year are listed on the accredited list published by the Joint Commission with no distinction made between them and others which have been fully accredited. The records of the Joint Commission show, however, that the hospitals not fully accredited have to be reinspected within one year (instead of three), and no certificate is issued.

Until January 1, 1958, there was an agreement between the A.P.A. and the J.C.A.H. whereby the latter accepted the inspections and ratings of mental hospitals by the Central Inspection Board for its own accreditation. In the future, both the Joint Commission and the A.P.A. Central Inspection Board will conduct separate inspections and issue their separate certificates and separate lists of approved (or accredited) hospitals. However, under the old agreement between the two organizations, the hospitals which were contracted *prior to June 1, 1957* for inspection by the C.I.B. will receive a certificate signed by both organizations if full approval is merited.

The A.P.A. bases its approval on the fundamental principles outlined by the A.P.A. Committee on Standards and Policies of Hospitals and Clinics, which are specifically concerned with the care and treatment of *psychiatric* patients, in addition to the departments covered by the Joint Commission inspections.

A public mental hospital, to be fully approved by the A.P.A., must make an over-all average of 70% of the standards set up by the Committee on Standards and Policies of Hospitals and Clinics and approved by Council. The percentage is obtained by the use of a rating scale developed by the C.I.B. with the help of a committee of hospital superintendents and this was also approved by the Council of the A.P.A. Certain essential departments—i.e. medical and nursing staff—must have a rating of at least 75%, and other essential departments—administration, physical plant, medical records, clinical laboratories, X-ray department, dietary department and patient care facilities—must have a rating of at least 70%. Nineteen other departments are also rated and are figured in the over-all average.

Public hospitals with an average over-all rating of 60 to 69% are conditionally approved, provided that no more than three of the "essential departments" fall below 70% and that neither the medical nor the nursing staff ratings fall below 60%. **Conditional approval is for three years, to enable the hospital to get funds appropriated and to make the needed improvements to earn full approval.**

Private hospitals are similarly rated, except that, to be fully approved, they must have an over-all average of 80% with none of the essential departments falling below 80%. (In a private hospital, the essential departments are administration, medical staff, physical plant, medical records, psychiatric treatments, medical services and nursing services.) A conditional approval is given to a private hospital with an over-all rating from 70 to 79% provided not more than three essential departments fall below 80%.

In the future, as already stated, the Joint Commission on Accreditation of Hospitals and the A.P.A. Central Inspection Board will conduct their own inspections, issue their separate certificates and publish an authorized list of inspected and approved hospitals.

Psychiatrists in Court

An immensely important stride toward making psychiatric testimony meaningful and effective in the administration of criminal justice was taken in District Court the other day by Dr. Addison Duval, assistant superintendent of St. Elizabeths Hospital. Dr. Duval made a courageous and realistic statement respecting the limitations of psychiatry. In doing so he illuminated the ways in which lawyers and judges and juries can make use of the knowledge and insights of psychiatrists as expert witnesses to help in understanding why a defendant committed the offense with which he stands charged. This understanding is the very foundation of justice.

A psychiatrist cannot tell a court whether a defendant is sane or insane—and ought not be asked to try—because, as Dr. Duval made clear, insanity is not a medical term or concept. What a psychiatrist can do by reason of his specialized medical training is to tell a court something of what went into a defendant's life, something of the dynamics of his mental condition, something, in short, of what led him to behave as he did. The great virtue of the much debated *Durham Rule*—which provides that a defendant is not to be held guilty if his offense was the product of a mental disease or defect—is that it provides at least a far better framework than the old right-and-wrong test within which a psychiatrist can furnish this kind of expert opinion. The final hard decision whether a defendant is guilty, or not guilty by reason of a mental disease or defect, must be made, of course, by a jury with some guidance from a judge.

Dr. Duval deplored the tendency of lawyers to ask the wrong questions—to try to get psychiatrists to testify about matters concerning which they have no special competence. He was quite justified in the complaint. Unfortunately, it is equally true that psychiatrists often seem eager to interpret the law. Since the psychiatrist's function is to supply facts, lawyers ought to ask questions calculated to produce facts. And since judgments based on the facts are to be made by the tribunal, psychiatrists ought to confine themselves exclusively to supplying medical information, not legal judgment. Dr. Duval's definitions, if carefully observed by lawyers and psychiatrists alike, can contribute valuably to making the administration of criminal justice a little more enlightened and a little more humane.

Reprinted from THE WASHINGTON POST & TIMES HERALD, May 4, 1958, p. E4

THE A.P.A. MENTAL HOSPITAL SERVICE—A BRIEF REVIEW

The A.P.A. was organized 114 years ago by thirteen devoted men who were superintendents of mental hospitals, and for many years the membership of the Association was made up almost exclusively of state hospital physicians. During the 19th century the private practice of psychiatry was practically unknown; thus the programs and interests of the Association dealt almost entirely with problems of mental hospital care.

As extramural psychiatry developed, however, relatively less attention was given to mental hospital problems. After World War II, therefore, it seemed fitting that emphasis should again be put upon the hospital and its problems of patient care and general administration.

Accordingly, in 1949 the first Mental Hospital Institute was held in Philadelphia. It was greeted with great acclaim by the participants and their hospital colleagues, with the resulting establishment of the Mental Hospital Service in January 1950. The Commonwealth Fund generously gave a grant to start the Service and 615 institutions accepted the offer of a free trial. In 1951 the Service was made self-sustaining at $50 a year.

The Bulletin, originally four to eight pages, has expanded into a very useful magazine, MENTAL HOSPITALS, now 48 pages or more a month—the only journal in the world devoted to the problems of mental hospitals. In addition to the monthly magazine, supplementary mailings of documents of special interest are sent out. There are at present 490 institutional subscribers, and in addition about 85 special organizations such as mental health societies and architectural offices.

The Institutes have been held annually with ever-increasing attendance and interest; they have furnished a highly valuable stimulus to persons interested in the business and professional problems of mental hospitals.

The total attendance to date has been almost 2,800. Achievement Award competitions have been held under the auspices of the Institutes, and 41 institutions have received recognition under this program.

The various activities of the Mental Hospital Service have been legion. A film loan service and a loan library of books have been developed. Various special projects, such as the Clothing Committee and the Volunteer Services Conference have been organized. The Architectural Study Project has worked closely with the Service, and has given impetus to new thinking in design.

The services have expanded in volume and quality, but these have resulted in increasing costs, in addition to the toll taken by rising prices and salaries. For the past few years the $50 fee has not met the cost of the service and as a result, further expansion has been greatly curtailed.

Elsewhere on this page will be found the details of a schedule of fees which has been adopted to meet financial needs for the present, at least, while at the same time recognizing the varying size of the subscribing hospitals as a basis for a sliding scale.

Your Consultants believe that the A.P.A. Mental Hospital Service is of value to the mental hospitals of the country, and urge your continuing support.

WINFRED OVERHOLSER, M.D.,
Chief Consultant

Schedule of Fees

The new fees for the Mental Hospital Service which take effect with the new subscription year are based on a sliding scale as follows. **The minimum fee is $50 and the maximum $350 a year.**

10¢ a bed for the first thousand beds
9¢ a bed for the second thousand beds
8¢ a bed for the third thousand beds
7¢ a bed for the fourth thousand beds
6¢ a bed over five thousand to $350

Commissioners' offices will remain at $50 per year. All foreign hospitals, including Canadian hospitals, will be $50 per year. Psychiatric units in General Hospitals will be calculated on the above scale and will be based on psychiatric beds only. Obviously, no hospital of less than 500 beds will be affected by the raise in fees.

Limited subscriptions will be raised from $15 to $25 per year. Individual subscriptions are fixed at $6.50 per year. (Single copies 65¢)

In accordance with a Post Office regulation, it will cost institutional subscribers $3.25 a year per extra copy. (The P. O. regulation requires that no individual subscription can be less than one-half of the fixed annual rate.) These increases will take effect July 1, 1958, for the majority of subscribers—January 1, 1959, for those whose subscriptions run by calendar year.

The number of copies sent to each hospital will be based on the fees as follows:

FEE	NO. COPIES	FEE	NO. COPIES
$ 50	10	$201-$210	30
$ 51-$ 60	15	$211-$220	31
$ 61-$ 70	16	$221-$230	32
$ 71-$ 80	17	$231-$240	33
$ 81-$ 90	18	$241-$250	34
$ 91-$100	19	$251-$260	35
$101-$110	20	$261-$270	36
$111-$120	21	$271-$280	37
$121-$130	22	$281-$290	38
$131-$140	23	$291-$300	39
$141-$150	24	$301-$310	40
$151-$160	25	$311-$320	41
$161-$170	26	$321-$330	42
$171-$180	27	$331-$340	43
$181-$190	28	$341-$350	44
$191-$200	29		

Because the other services offered by Mental Hospital Service (films, etc.) are not available to them, foreign hospitals, including Canadian ones, will receive 15 copies of the magazine for their $50 fee instead of the 10 copies indicated above for United States hospitals who do have access to the additional services.

No. 9 in a Series

MANAGEMENT AND THE WARD PHYSICIAN

By C. H. CAHN, M.D.

Senior Psychiatrist, Verdun Protestant Hospital, Montreal, Quebec

THIS PAPER ATTEMPTS to show the extent to which the principles and techniques of scientific management, as outlined by Dr. Addison M. Duval,* can be applied in a public mental hospital at the ward level. The discussion will not be limited to one ward only, but will include all the wards in this particular hospital in which female patients reside. The point of view, therefore, will be that of the senior psychiatrist "in charge of" female patients.

The words "in charge of" have been placed in quotation marks in order to illustrate the first point: How clearly can and should the work and the responsibility of the senior psychiatrist be delineated? The clinical director is "in charge" too, as is the medical superintendent. So is the ward physician, and so is the nurse "in charge" of the ward. These people are all in charge in different ways and play different roles. Thus, the more clearly each knows his own particular function and limits, the less likely it is that one will interfere with another or think that a particular job is not his responsibility but somebody else's.

At our hospital several years ago the medical superintendent prepared separate descriptions of the duties of the senior psychiatrist, the residents in psychiatry and the interns. Mimeographed copies of these three lists are issued to each physician when he starts to work in the hospital. Thus each doctor knows the nature and extent of his duties and those of the others, that is, of those below the rank of clinical director. The exact duties of the medical superintendent, the assistant medical superintendent, and the clinical director have not been similarly spelled out, which leaves the possibility of some confusion in the minds of the senior psychiatrist, the residents and the interns as to the exact duties of the "top three". This has not, however, caused any major problems.

Along with job description, Dr. Duval mentions the importance of *Standards of Performance,* i.e., written statements of conditions that will exist when the job is well done, and he deplores the lack of such standards in most mental hospitals. We have not been able to apply this particular management tool, but one wonders what might happen if all the members of the hospital staff knew they were being constantly scrutinized to see if their day-to-day performance measured up against standards explicitly written for their jobs and perhaps displayed in some more or less prominent place. I would venture to predict that this might increase the already high pressure under which some of the hospital staff members are working, and in some cases impair rather than improve their efficiency. On the other hand, there are some individuals who are not quite sure how well they are actually doing their work and who would like to know more definitely. If there is no one to help them assess their work they lack a certain sense of security which in turn may lower their morale and impair their efficiency. Such an individual would be greatly helped by clearly stated standards of performance which he could use as a guide to direct his day-to-day work. A third type of person, characterized by a little more self-reliance, would probably not be particularly affected by what other people think in this respect, and would presumably know himself how well he is doing his job.

I shall now go through some of the principles outlined in Dr. Duval's paper in the same order in which he classified them.

Priority System Established

First, *Planning.* The senior psychiatrist has a considerable variety of functions and responsibilities. The main ones are diagnosis, treatment, and periodic reassessment of all the cases on his service, and frequent communication and contact with all others concerned (especially with the clinical director, the ward physicians and nurses and, to a lesser extent, most of the other hospital personnel, as well as with the patients' relatives and visitors, etc.). Finally, there are supervision, teaching and training activities, committee work, and participation in two or three current investigations. Hence he must carefully plan and organize his working time. Many of these activities are routine and repetitive and can be scheduled, but from time to time new activities are added and unexpected situations arise which seriously interfere with any schedule. In order to keep the schedule flexible, we have established a *system of priorities,* the main objective of which is "first things first," "second things second," and so on.

The approximate order of priority is as follows: 1. Emergencies; 2. Lectures to medical students and other teaching assignments; 3. Attending conferences; 4. See-

* *MENTAL HOSPITALS, October 1957.*

ing new patients; 5. Seeing relatives and friends; 6. Supervising treatments ordered or carried out by ward doctors; 7. Individual and/or group psychotherapy; 8. Rounds on and off wards; 9. Dictating notes and attending to correspondence; 10. Miscellaneous.

An example of planning at another level is with respect to group therapy. The selection of patients for groups is to some extent based on two main and quite different objectives: (1) The preparation of patients for discharge from hospital and dealing with post-discharge problems for those whose prognosis for discharge is good; and (2) The better adjustment within the hospital of those patients whose prognosis for early discharge is poor. Our experience is that if group therapy sessions are not planned according to these objectives the results we achieve are much less beneficial.

As to *assignment of responsibilities* to other individuals, this is not a major area for the senior psychiatrist where most of the responsibilities have already been assigned by the medical superintendent and the clinical director. The senior psychiatrist of course has to exercise judgment about what tasks he should take on himself and what tasks he can entrust and assign to the ward physician. In most cases the latter is a psychiatric resident who usually has a certain amount of previous psychiatric experience, but who is sometimes unwilling to take on special responsibilities which he regards as "administrative" and therefore unimportant or uninteresting. Keeping in mind the kind of training the resident desires to obtain and should obtain (not always the same thing!), the senior psychiatrist has to adjust his attitude accordingly. One example of this problem is the transfer of patients from one ward to another. The ward physician is asked to have available the names of a few patients who could be transferred from his ward. The ward physician may not wish to be bothered with this "administrative" duty, which is additional to his many other duties. In this case, the senior psychiatrist may at first decide to take it on himself, but gradually persuade the ward physician that handling this matter may be of some benefit to him after all. By explaining the reasons, and showing by example how such a transfer is best accomplished, the senior psychiatrist can teach the ward physician a management technique that he will find useful sooner or later.

The next management principle is that of *"Controlling"*. Dr. Duval describes the two elements of organizational structure and supervision. From the senior psychiatrist's point of view, the latter is the more important of the two. He directly supervises all the ward physicians on his service. (At present there are nine on the author's service.) He makes it his duty to be aware of the ward physicians' assets and liabilities, supporting the former and helping out with the latter. Occasionally he has to be careful that he is not too much of a supervisor! I know of one instance where a particular resident felt that the senior psychiatrist was hovering over him like an over-maternal hen. The resident was not able to communicate this directly, but brought it out in the open in a group session where he felt that he had the backing of the other residents. As a management technique, regular group sessions of this kind—where the ward doctor feels he can speak freely—are an effective means of communication, especially when other means appear to be blocked. In the group, the senior psychiatrist can observe some of the ways in which the ward physician functions and he can act both as a manager and as a sort of therapist, as the occasion demands. These group sessions do not, of course, take the place of individual supervision, but merely supplement it. Neither do they take the place of formal staff conferences.

Controlling includes review and appraisal, both of the work and the workers. This aspect of ward management is more or less covered by informal discussions with the ward physicians, clinical director, and others concerned, as well as by gathering information directly on the wards and those off-the-ward areas where patients might be occupied. In this way one frequently finds improved methods of getting the work done. The patients' clinical records and progress notes are also reviewed periodically, and errors or omissions are pointed out and corrected.

The above remarks make it unnecessary to consider in detail the *Executive Function* and the *Management Formula,* which are the next two subheadings in Dr. Duval's paper. We have not applied the seven steps of the Management Formula as listed by Dr. Duval as an integrated whole and in the sequence indicated, but individual methods, such as organization clarification and time schedules for action, have been employed frequently for many years.

Management Skills and Tools

It is difficult to comment on the subject of *Management Skills* in the short space that remains. I shall briefly pick out one: Integrating viewpoints of people and of functions. The senior psychiatrist in his daily contact with his colleagues and other professional staff hears many different opinions voiced, ranging from friendly suggestions to occasional hostile clashes, and from reasonable requests to emotionally colored demands. He obtains the best results when he succeeds in detecting the true needs behind the opinions expressed, promptly finds acceptable ways of satisfying these needs, and at the same time explains the reasons for his own actions, especially if he does not respond exactly in the expected manner.

Dr. Duval lists thirty-six *Tools of Management.* Some of these are not, of course, directly applicable at the ward level. Of those that are, one might particularly select the following:

1. Forecasts of patient load and availability of staff; 2. Standards of Performance (see above); 3. Organization structure; 4. Personnel utilization techniques; 5. Ward statistics, e.g., patient turnover; 6. Appraisals, especially rating scales and review conferences; 7. Communications systems.

We must admit that so far we have not given much conscious thought to any but the last two mentioned in this list. However, we have always stressed the importance of adequate multilateral communication, and have used different methods of facilitating the transmission of information to those who have to take the appropriate action.

Now some remarks about *Self-Management.* Although

not mentioned by Dr. Duval, I believe it worthwhile to list some principles of this important aid to ward management:

1. Proper motivation; 2. Good work habits; 3. Time schedules; 4. System of priorities; 5. Keeping oneself well informed; 6. Periodic self-assessment.

Unsolved Problems

Finally, I should like to state what I consider to be some problems as yet unsolved in this field of management, and thus subject to further investigation. First, the relationship between management and therapy—to what extent can one increase one's working efficiency without loss of humanity? In other words, what does a well-oiled machine do to the human spirit? And, secondly, should you try to develop more and more techniques of management, deliberately thought out and carefully planned, to take the place of common sense, or is it better at times to "trust your instincts" and deal with the problems spontaneously according to what the situation demands, without having recourse to this management formula or that management skill?

Certainly the application of scientific management principles is of value at the ward level. We must remember, however, that the clinical orientation of ward management imposes certain limitations on the extent of application.

Central Dining Plan Encourages Sociability

In keeping with the trend towards the "open door," we began, at Hawthornden (Ohio) State Hospital, to plan for more patients to eat their meals in the central dining room. The hospital is built on the cottage plan and the dining hall is near one end of the grounds. This means that some patients who have not been away from their cottages for several years now walk a good distance several times a day and mingle with other patients and personnel.

The effect is startling. Each day patients show improvement; in better grooming, cleaner dining habits, greater sociability and more tidiness in dress, as well as nutritional improvement.

With more patients eating in a central location, and thus fewer individual dining rooms in operation, we have been able to cut down the number of food trucks and food service personnel. In addition, the food served from the central steam table is hotter and more appetizing.

Patients and personnel are enthusiastic about the plan. The results are so rewarding that more cottages are expected to begin using the central dining room.

JANE S. KAZDAN, R.N., M.A.
Acting Director of Education

IT'S ALL RELATIVE!

By Dr. WHATSISNAME

When the new Superintendent came to Gargantuan State Hospital he asked his department heads: "How about liberalizing visiting hours?". The Director of Nurses said, "No; relatives take up too much of the nurses' time in the wards and upset ward routine." The Clinical Director said, "No; I can handle the patients easily. It's the visitors that give us the ulcers." The housekeeper frowned on it. The police officers pictured an uninterrupted parking problem. The coffee shop people said they couldn't brace themselves for the relentless run on ice cream and candy. So the vote was 6 "no's" with only the Superintendent voting "yes". But the ayes had it, this hospital being run on the hierarchical, not the democratic plan.

Visitors used to come every Sunday plus the first Saturday of each month. Now they are welcomed every day in the year between 11 a.m. and 3 p.m. The first result was a spreading out of relatives so that instead of 800 visitors on a Sunday, there are now 400 on Sunday, 300 on Saturday and about 60 each week-day. Parking is thus easier. The coffee shop manager finds that his load is spread more evenly throughout the week. And while the doctors are now spending some time with visitors every day, the Superintendent doesn't care. He thinks that public relations is part of their job and that contact with relatives is important in understanding the patient. Social service finds its burden evened and lightened. Ward housekeeping is disturbed, however, and the grounds foreman complains that his campus now looks like a picnic ground. But the Superintendent explains that groundskeeping and housekeeping are for the patients' comfort. The patients, he suggests, are not there for the sake of ward or grounds maintenance.

The other Superintendents in the state hospital system shake their heads. "Have to show relatives who's in the driver's seat," says the Superintendent of the First State Hospital. "It can't work," says the Superintendent of Second State, "It is just theory." At Third State the Superintendent says you can't treat patients with relatives running all over the place. But at Third State Hospital (just between ourselves) they don't treat the patients anyway.

"Relatives," say the other Superintendents, "are poison. The shorter the visiting time the better."

The better? For whom?

Typical case: "unmanageable" schizophrenic patient is hostile, untidy and inaccessible to therapy.

the "before-and-after" picture in mental wards continues to improve, case after case, with **Serpasil**® (reserpine CIBA)

With Serpasil, patient becomes calm, cooperative, amenable to interview . . . as have thousands in this new age of hope for the psychotic.

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COLUMBIA GRADUATES FIRST ADMINISTRATIVE PSYCHIATRISTS

THE FIRST official visitors to the new A.P.A. Central Office building in Washington were six psychiatrists who are studying administrative psychiatry at Columbia University, New York City. Three of them graduate this month from the University's 20-month course in administrative psychiatry, receiving a Master of Science degree in administrative medicine—they are the first graduates of the course. The three are Dr. J. M. Byers, Assistant Medical Superintendent of the Provincial Mental Hospital, Ponoka, Alberta; Dr. Franz Hasselbacher, Clinical Director of the Connecticut State Hospital, Middletown; and Dr. Joseph J. Sconzo, Supervising Psychiatrist at Central Islip State Hospital, New York. Two others—Dr. Israel Kesselbrenner, Supervising Psychiatrist at Manhattan State Hospital, N.Y., and Dr. Robert E. Weimer, Assistant Superintendent of Mayview State Hospital, Pa.—are completing their first year in the course. The sixth visitor, Dr. Donald H. Schultz, is one of three psychiatrists on two-year post-residency fellowships for combined training in community and administrative psychiatry.

The visit to the A.P.A. Central Office was part of a four-day field trip in which the students also visited the National Institute of Mental Health and the Mental Health Study Center, in nearby Maryland.

The course in psychiatric administration is conducted under the joint auspices of the School of Public Health and Administrative Medicine and the Department of Psychiatry, Faculty of Medicine, Columbia University. It is financed by grants from the U.S. Public Health Service and from the Grant Foundation. The course leads to a Master of Science degree in Administrative Medicine. At the present time candidates for the course must be qualified psychiatrists, preferably from an administrative position.

Course Runs 20 Months

The program was first offered in September, 1956. The 20-month curriculum includes eight months spent in academic residence; and 12 months spent in a supervised administrative residency in a psychiatric setting during which period the candidate carries out and writes up a specific project. This training residency requirement can, with Faculty approval, be fulfilled in a position already occupied by the candidate.

The program is designed to prepare candidates for administrative posts in mental hospitals, psychiatric clinics and in community mental health programs. An objective of the course is to supplement the students' previous training and experience by an emphasis on the community and its social institutions as these relate to psychiatric facilities and programs. Curriculum content is divided about equally between selected basic courses in administrative medicine and public health and special courses related to the functions of psychiatric facilities.

The basic public health-administrative medicine content includes courses on principles of administration, hospital organization and management, personnel practices, financial management and accounting, housekeeping and purchasing, dietary, physical plant and maintenance, medical records, biostatistics, public health surveys, problems of medical care, hospital construction, public health education. These courses are selected from those given to all general hospital and medical administration students at the school.

Seminars and Field Visits Included

The specialty content, particularly related to the psychiatric field, is under the direction of Dr. Viola W. Bernard, who coordinates the joint program as head of the Division of Community Psychiatry in both the Department of Psychiatry and the School of Public Health and Administrative Medicine. The specialty content of the course is presented through several series of weekly seminars; field visits for observation and discussion of a variety of forward-looking community psychiatric services and related agencies; and by special courses. These courses include: the financing of mental health programs, legal aspects of psychiatric administration, group dynamics, the administrator's role in milieu therapy, psychiatric epidemiology and psychiatric hospital administration. In addition, a day a week is devoted to the examination of a mental hospital, department by department, during the first two quarters, and a project in psychiatric administration is carried out during the training residency.

The weekly seminars, conducted by outstanding leaders in psychiatry and related fields, cover a wide range of content: recent developments and trends in psychiatry, training and functions of related divisions such as psychology, social work, nursing, occupational therapy; communications, public relations and education for mental health; special areas and developments related to community and administrative psychiatry in the social sciences, religion, rehabilitation, research, residency training programs and the use of volunteers. In the fourth quarter this year the candidates spent one day a week in a nearby mental hospital as participants in meeting live issues and problems with the Director and his staff.

The weekly field trips are made to settings chosen for diversity of mental health services and patterns of interprofessional teamwork and preventive, therapeutic

and rehabilitative programs. A special weekly seminar provides the students with an opportunity to discuss their observations and the implications of the programs observed.

This course in psychiatric administration was undertaken in response to the needs for special training as recognized by the Committee on Certification of Mental Hospital Administrators of the American Psychiatric Association.

So far, all of the students have been continued on salary by their employing institutions and have received supplemental grants through the National Institute of Mental Health to defray additional costs incurred in taking the course.

Applications are now being accepted for the course starting in September 1958. Information is available from Ray E. Trussell, M.D., Executive Officer, Columbia University School of Public Health and Administrative Medicine, 600 West 168th Street, New York 32, N.Y.

Suggested Staffing Formula

An intriguing staffing formula is proposed in the Study of Standards for Psychiatric Inpatient Care for the New York City Community Mental Health Board, recently released by Dr. Daniel Blain and Dr. Ralph M. Chambers. The formula and its interpretation follow, for the benefit of budget-makers:

Psychiatrists (full-time, part-time and students)

TTR institution $P = \frac{C + A}{25}$

DSR institution $P = \frac{C + A}{25 \times 5}$

(P stands for psychiatrist; C for bed capacity; A for Annual Admissions. TTR stands for Teaching, Training and Research institution; DSR for Diagnostic, Screening and Referring institution.)

Nurses (professional & non-professional; students counted 2 for 1)

TTR institution $P + NPN = \frac{\frac{C + A}{10} + C}{2}$

DSR institution $P + NPN = \frac{\frac{C + A}{30} + C}{2}$

(P stands for professional, NPN, non-professional. Other symbols as above.)

Social Workers (students counted full-time)

TTR institution $S.W. = \frac{C + A}{50}$

DSR institution $S.W. = \frac{C + A}{300}$

(S.W. stands for Social Workers.)

Psychologists—Until further study, the same formula as for social workers may be applied.

USES OF THE PAST

II. Hospitals and Modern Psychiatry

MAN HAS ALWAYS been faced with the necessity of dealing with his fellow beings who have suffered from varying degrees and types of emotional and mental aberrations. History records different approaches, which have ranged from humane treatment to medieval witch hunts. The Renaissance brought an increasing enthusiasm for the objective study of nature, which gradually shifted to include the science of man, starting with anatomy, followed by physiology and chemistry, and later, by psychology and sociology.

When this movement combined with the 18th century ideas of freedom, equality and humanity, there came a growing emphasis on accepting the "insane" as ill people who were to be treated by humane and medical procedures in a hospital. Among those who especially furthered the birth of modern psychiatry were Vincenzo Chiarugi in Italy, Joseph Daquin in France, Johann Langermann in Germany, Philippe Pinel in France, Benjamin Rush in the United States and William Tuke, the only non-physician, in Great Britain.

The first psychiatric hospital in the United States, the Eastern State Hospital at Williamsburg, Virginia, was founded in 1773 and was run under lay auspices. The Pennsylvania Hospital, The New York Hospital and the Public Hospital of Baltimore, all received psychiatric patients, but the next exclusively psychiatric hospital was founded, like Tuke's York Retreat, by the Quakers in 1817, as the Friends Hospital. This served as a guide and inspiration for McLean's Hospital (1818), Bloomingdale (1821) and the Hartford Retreat (1824). By 1860 some 40 additional asylums had been established.

Although these hospitals varied in size, location, type of patient admitted and quality of direction, they all followed in general the mode of therapy then current. This was usually divided into medical therapy, which varied considerably depending on the beliefs and enthusiasms of the individual doctor, and moral therapy, which referred broadly to all parts of patient management that were non-medical, but more specifically to dealing with the various mental peculiarities of each patient. This was the psychotherapy of that age, which because of its prominence, has caused the period to be called the "moral treatment era".

With this therapy, the first step was to place the patient in a hospital so as to remove him from old associations. The patient was approached with enthusiasm and optimism which aroused within him the expectancy of recovery. He was accepted as a fellow human being in difficult and consequently, was to be treated with kindness but with firmness if necessary, without deception and with a minimum of restraint and coercion. He was supported and distracted by an active program of occupational and recreational therapy, while re-education was effected through discussions with his physician, and by classes and religious services. The value of this therapeutic era, which went into decline after the Civil War, can best be evaluated by the results obtained, which will be discussed in the next article.

ERIC T. CARLSON, M.D., New York, N. Y.

PRELIMINARY PROGRAM TOPICS FOR TENTH MENTAL HOSPITAL INSTITUTE

Hotel Muehlebach, Kansas City, Missouri, October 20 through 23, 1958

MONDAY, OCTOBER 20th

PERSONNEL NEEDS ARE CHANGING: New concepts of the environmental and therapeutic needs of patients call for new kinds of employees. There should also be re-evaluation of the duties and possibly redistribution of existing personnel.

Dr. Howard P. Rome
Mayo Clinic, Rochester, Minn.

ORGANIZING TO MEET NEW PERSONNEL NEEDS: To run a truly therapeutic hospital, we must meet the needs of employees as well as of patients. It is the responsibility of institutional management to recognize and meet the needs of today's higher type of employee.

Dr. Harold L. McPheeters
Commissioner of Mental Health
Louisville, Ky.

TRAINING OF WARD PERSONNEL: We depend to a large extent on ward personnel to help create the therapeutic atmosphere we require. Because their function is no longer largely custodial, they must be trained to take a more active part in bringing about improved treatment of patients.

Tirzah M. Morgan, R.N., N.I.M.H., Bethesda, Md.
Second leader to be announced

FULL UTILIZATION OF ANCILLARY PERSONNEL: The patient's world is no longer limited to the ward. It is therefore mandatory that full utilization be made of the skills of all ancillary therapists.

Mr. Donald C. Pritchard, Coordinator,
Physical Medicine and Rehabilitation
VA Hospital, North Little Rock, Ark.
and Dr. David W. Harris
St. Elizabeths Hospital, Washington, D. C.

RECRUITING AND RETAINING PERSONNEL: High personnel turnover is the single most wasteful factor in the hospital budget. The establishment of a well-staffed personnel division can greatly reduce this waste by more effective recruitment, selection and orientation of employees, and coordination of in-service training programs.

Dr. T. Glyne Williams,
Yale University, New Haven, Conn.
Second leader to be announced

TUESDAY, OCTOBER 21st

VOCATIONAL REHABILITATION IN THE MENTAL HOSPITAL: Because of better treatment methods, a larger number of long and short term patients can benefit from realistic vocational training. An effective program for suitable patients would also decrease readmission rates.

Dr. Harold R. Martin
Nebraska Psychiatric Institute, Omaha

ACADEMIC LECTURE **To be announced**

PSYCHOANALYTIC CONTRIBUTIONS TO TREATMENT PROGRAMS IN MENTAL HOSPITALS: The psychoanalyst has much to contribute to the teaching and treatment program in the modern mental hospital. Teaching staff to apply short term psychoanalytic techniques is but one way to utilize the special competence of this discipline.

Leader to be announced

MENTAL ILLNESS AND PREPAYMENT OF INSURANCE PLANS: Prepayment of hospital costs by insurance plans could relieve taxpayers and families of the excessive financial burden of mental illness. Is it feasible to extend these plans to cover hospitalization for mental illness?

Dr. Charles A. Roberts,
Verdun Protestant Hospital, Montreal, P.Q.
Second leader to be announced

WEDNESDAY, OCTOBER 22nd

THE MENTALLY RETARDED—A COMMUNITY RESPONSIBILITY: The community has never accepted its share of responsibility for the rehabilitation and utilization of mentally retarded individuals. Educational and vocational centers at the community level might lessen the burden on institutions by making these people partially self-sustaining.

Leader to be announced

RECENT DEVELOPMENTS IN THE TREATMENT OF ALCOHOLISM: More hopeful attitudes toward the treatment of all phases of alcoholism have increased the responsibility of mental hospitals to provide effective treatment programs.

Leader to be announced

ADMINISTRATION OF THE HOSPITAL PHARMACY: Budget allocation for drugs has increased by leaps and bounds during the last five years. The pharmacy is no longer a closet for sedatives, laxatives and cough syrup. A well constituted Pharmacy Committee, working in close cooperation with the medical staff, can see that drugs are effectively purchased, dispensed and administered.

Leader to be announced

APPLICATION OF RESEARCH FINDINGS TO THE HOSPITALIZED EPILEPTIC:

Leader to be announced

HOUSEKEEPING PROBLEMS OF THE MENTAL HOSPITAL: Scientific housekeeping methods have rarely been applied to the mental hospital. There is need for a complete re-appraisal and perhaps reorganization of housekeeping functions in the mental hospital.

Leader to be announced

ADMINISTRATIVE CONTROLS OF MATERIAL: A standards committee can set quotas for ward supplies and linens. Preprinted requisitions have advantages. A qualified Administrative Assistant should be responsible for coordination.

Mr. Alexis Tarumianz, Business Administrator
Delaware State Hospital, Farnhurst

THURSDAY, OCTOBER 23rd

NEW FRONTIERS IN THE MENTAL HEALTH EFFORT: The search for new, strange and unusual ways of solving problems interests every hospital administrator. What wild ideas have you been too embarrassed to speak about?

Dr. Dale C. Cameron, Medical Director
Department of Public Welfare, St. Paul, Minn.

ADAPTATION OF OLD BUILDINGS TO NEW NEEDS: During this period of rapid development of new programs, hospital superintendents face the problems of running new programs in old unsuitable buildings. What interim measures can be taken—modernization of structure, specially designed furniture, etc.—to make them serviceable for present requirements?

Dr. Charles E. Goshen
Central Office, A.P.A.
Second Leader to be announced

INTENSIVE TREATMENT OF THE SENILE PSYCHOTIC: Experience abroad and pilot studies in this country indicate that the senile psychotic can be effectively treated by intensive methods in or out of the mental hospital. A description of methods and a review of statistics will show that death rates can be reduced, the number of discharges increased and the period of hospitalization shortened.

Dr. Robert C. Hunt
Hudson River State Hospital
Poughkeepsie, N. Y.

INFORMATION ABOUT THE TENTH INSTITUTE

The Program of the Tenth Mental Hospital Institute has been developed under the chairmanship of Dr. Cecil Wittson, working with Drs. William S. Hall, Mary V. Jackson, Francis J. O'Neill, Mr. Donald Shropshire and Mr. Alexis Tarumianz. There are several minor changes in the format this year.

The Institute is to be held at the Hotel Muehlebach, Kansas City, Mo., October 20 to 23. The Local Arrangements Committee advises us that early advance hotel reservations are essential, because the American Royal Livestock Show is held in Kansas City during the same week.

On the afternoon of the first day, the three topics on Training, Utilization and Recruiting of Personnel are to run simultaneously from 1 p.m. to 4 p.m., to offset the difficulty of obtaining extensive participation from a group of four hundred or more people. From 2:20 to 2:40 p.m. there will be a twenty-minute break, after which the second of the Discussion Leaders named will take over the leadership of the discussion.

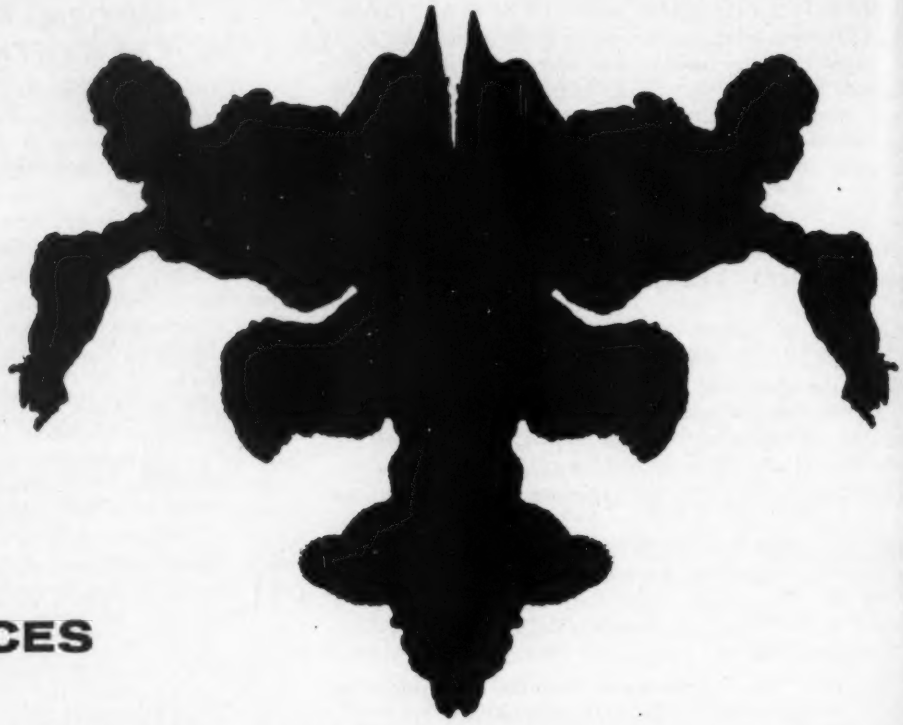
The regular Simultaneous Sessions on topics of special interest are to be held as usual, this year on Wednesday morning. Brief reports will be given at 9 a.m. on Thursday, before the main plenary session.

Space in the hotel is available all day Sunday for other private meetings. The Business Managers will meet at this time, and two other groups, the Coordinators of Volunteers and the Mental Health Educators, have requested space for meetings of their own. Arrangements to reserve space for any other group should be made as early as possible with Mrs. Phyllis Woodward of the Mental Hospital Service, who is responsible for the administrative aspects of the Institute.

On Tuesday evening, the Commissioners of Mental Health from the various States will hold their meeting. On this evening too there will be the usual informal party, as well as an exhibit of audio-visual aids for hospitals, which is being designed and arranged by Dr. Charles E. Goshen, of the A.P.A. Central Office.

One major change this year concerns the fees for attending the Institute. **No longer may the second staff member of a subscribing hospital come for a reduced fee. The fee for each Registrant will be $50.** This fee includes lunches (except Wednesday), the dinner and cocktail party on Monday night, the informal beer party, distribution of all written material and a copy of the published Proceedings.

Chairman of the joint Kansas-Missouri Local Arrangements Committee is Dr. William F. Roth Jr., Kansas City, Kansas. Other members of this two-state arrangements group are as follows: KANSAS: Dr. Howard V. Bair, Dr. Alfred Paul Bay, Dr. Merrill T. Eaton, Jr., Dr. George Jackson, Dr. Irving Kartus, Dr. Milton E. Kirkpatrick, Dr. Richard F. Schneider, Dr. Roderick G. St. Pierre, and Dr. George Zubowicz. MISSOURI: Dr. Paul L. Barone, Dr. Edward E. Baumhardt, Dr. Ralph E. Duncan, Dr. Orr Mullinax, Dr. W. E. Olson, Dr. Albert Preston, Jr., and Dr. G. Wilse Robinson, Jr., Secretary.



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ANNOUNCES

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- increasing accessibility for psychotherapy

Improves patient-personnel relationship by:

- diminishing patient destructiveness
- bettering ward behavior

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- photosensitivity—rare
- hyperthermia—rare
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By special request from our readers, MENTAL HOSPITALS will publish each month the dates and locations of the next two A.P.A. Annual Meetings and Mental Hospital Institutes.

ANNUAL MEETING

1959 Apr. 26-May 1	Municipal Auditorium	Philadelphia
1960 May 9-13	Convention Hall	Atlantic City

MENTAL HOSPITAL INSTITUTE

1958 Oct. 20-23	Muehlebach Hotel	Kansas City
1959 Oct. 19-22	Statler Hotel	Buffalo

Teaching Program Set Up for R.N. Aide Instructors

The National League for Nursing, in cooperation with the A.P.A. recently launched a nation-wide seminar program designed to increase the effectiveness of nurses conducting on-the-job training programs for psychiatric aides. Miss Anna Fillmore, General Director of the N.L.N. says that the seminars are open to instructors from all types of mental hospitals.

The project, known as the Seminar Project for Teachers of Psychiatric Aides, will be guided by a joint N.L.N.-A.P.A. Committee, composed of Miss Kathleen Black, Miss Garland K. Lewis, Mr. Frank J. Shea and Miss Lavonne M. Frey of the N.L.N., and Dr. Daniel Blain and Dr. Granville L. Jones of the A.P.A. It is financed by a grant from the National Institute of Mental Health. Miss Lewis is the project director.

The project started on May 1st with the establishment of six two-week seminars for aide instructors from North and South Carolina, Tennessee and Arkansas. Each group of 12 aide instructors (R.N.'s) is under the leadership of clinical specialists in psychiatric nursing. Thus some 72 teachers will be involved in the first phase of the program.

Seminars focus on mental patients and their feelings, and on the teachers and their feelings toward patients. Interaction between patients and nursing personnel is emphasized so that teachers may learn how it relates to changes in attitudes and behavior of patients.

The time will be divided among observation of patients on hospital wards; group and individual discussions under the instructors; and the study of pertinent literature. There will be an opportunity for participants to teach a small group of aides under supervision.

The project structure also calls for the establishment of regional committees which will include representation from psychiatry, psychology, sociology and the aide group, as well as wide nursing participation from mental hospitals, schools of nursing and the state psychiatric nursing consultant. Local planning committees will also be established in each state as the project proceeds.

The future programs in other parts of the country will be based on the evaluation and results of the initial stage of the project in the four southern states.

Itemized Waste Tests Aid Menu Planning

Waste tests on meals served at Richmond State Hospital, Indiana, are taken at regular intervals in both patients' and employees' dining rooms to determine the plate waste and garbage cost of each item served.

The day before a test meal is scheduled, each scullery area receives a typed form on which the attendant records the amount of plate waste.

On the day of the test all food used in preparation is weighed and the total weight for each menu item is noted. When the food is dipped for serving, the weight of each item and the area where it is served are recorded. (The total dipped weight should equal preparation weight.) After the meal the plate waste is separated by item and weighed and the amount of total waste as well as the waste per item is recorded.

When all the forms are returned to the office of the dietitian, she determines the cost of each item served, percentage of waste per item, dollar loss, poundage of waste, and the cost of garbage.

These tests have helped us in menu planning to eliminate foods which were found unacceptable, to serve less often those which are only moderately well liked, and to establish better portion control.

In the first year of operation this system reduced our cost of waste from 15¢ to 8½¢ per pound.

ALTA LONG HUMMEL
Chief Dietitian

The HIGH Cost of the Low Bid

By A. C. YOPP, Director of Administration
Arkansas State Hospital, Little Rock, Ark.

PUBLIC MENTAL HOSPITALS have made a great deal of progress in recent years even though countless problems are ever present to retard improvements. Among the many obstacles constantly facing administrators is their apparent inability to procure items of equipment and supplies necessary to maintain an acceptable operation. One often hears complaints from administrators that because of state purchasing laws and the failure of state purchasing officials to understand the administrator's problem, they are forced to accept goods which are far below desired standards.

Most purchasing laws give the state purchasing director wide latitude in making awards to vendors. They are usually written to allow certain purchases to be made by the hospital and others through the central purchasing authority. But purchasing officials often interpret regulations and laws differently. While they are permitted to make an award on the basis of the lowest and best bid, what constitutes the "best bid" is often a source of disagreement between the state purchasing official and the hospital procurement officer.

The state purchasing official who is not fully acquainted with conditions under which the product is to be used may award the contract to the lowest bidder, disregarding the "best bid" from the standpoint of the hospital's needs. On the other hand, the hospital will, in most cases, accept the best bid, which may not necessarily be the lowest. If one so interprets the law that only the lowest bid is considered, the purchase frequently turns out to be the most costly. Hidden costs, which may be concealed in various ways, must be considered along with the initial price to determine if the cost is "best and lowest" within the broad framework of purchasing laws. Often the hospital finds it impossible to standardize certain items of equipment because of the state purchasing official's rigid interpretation of the laws. In viewing this problem, however, one must realize that the state purchasing official is operating under a function of government which has as its chief aim the procurement of items needed for the State *at the lowest possible cost,* whereas the hospital has as *its* chief aim service to human beings.

Reasons for Uniformity

From the standpoint of the hospital there are many reasons why some items of equipment need to be standardized. Some of these are: (1) replacement parts are interchangeable and standardization reduces the necessity of carrying parts for more than one type; (2) service may not be available in the local area, which may result in a piece of equipment's being out of use for long periods of time; and (3) there is a saving in labor because it takes time to train employees to operate and service different makes of machines.

Every administrator has had experiences in which the low bid was accepted and further expenditures were necessary in order to use the item purchased. Several years ago, a hospital constructed a new medical and surgical building, but did not have sufficient funds in its construction account to fully equip the unit. The architect, therefore, was instructed to design the building and rough in electrical and plumbing outlets for installation of equipment to be purchased from operating funds. Roughing in of electrical circuits and plumbing was made to fit the specifications of sterilizer A. The institution submitted a purchase request to the state purchasing director, together with a complete description and specifications for sterilizer A. The low bid was submitted by a firm that sold sterilizer B. Over loud protests from the hospital superintendent and others, the purchasing director awarded the contract to the low bidder for sterilizer B! Sterilizer B was shipped to the institution and when engineering personnel attempted to install the equipment, they found, of course, that none of the electrical or plumbing outlets would fit. It was necessary to remove a part of a glazed tile wall and floor and to reset plumbing and electrical outlets to accommodate the sterilizer. Cost of installing the low bid item in this case amounted to something over $400. To add insult to injury, the sterilizer broke down some years later and when replacement parts were ordered, the hospital found that the piece of equipment was no longer manufactured — the manufacturer had gone out of business shortly after World War II.

Other examples might be simply stated by asking a question. Why buy typewriter A for a secretary receiving $300 a month when she had her training and several years experience on typewriter B? If the secretary is going to be unhappy on the job and her efficiency is jeopardized, common sense would dictate that it is more economical to purchase typewriter B. The same thing would hold true for many other types of equipment used in a hospital.

An insignificant item like carbon paper, which is used quite extensively in all hospitals, would not appear to create a problem. Just recently, however, we ran a test on the durability of a higher priced carbon paper. The costly paper produced legible copies ten times as long as the cheaper type. To purchase the low bid on such an

item is not only more expensive but causes more work for the typists.

I sometimes suspect that we hospital people become overly concerned about the occasional incidents when equipment is purchased by the state purchasing officials which does not meet the needs of the hospital, yet we disregard the type of items purchased for day to day use. The bulk of our appropriation, except for salaries, is spent for food, drugs and supplies. It is with these items that we are most concerned in the Arkansas State Hospitals.

A simple, inexpensive item may cause extensive damage to valuable floors and furnishings. If, for instance, improper cleaning detergents are used on the floor, damage results which may be costly to correct. Most hospitals have floor coverings ranging from asphalt tile to terrazzo and hardwood and floor coverings can be best maintained by using the detergents and waxes specifically designed for them. The detergent used in the dishwasher may not remove bacteria and grease, causing patients to eat from contaminated dishes, which in turn creates other undesired effects. Moreover, the dishwasher may corrode and require extensive overhauling at frequent intervals. All of these things add up to personnel time and extra cost.

Arkansas Officials Progressive

We are fortunate in Arkansas to have state purchasing officials who are flexible in their thinking and dedicated to doing the very best job they can for the institutions by purchasing the items that we need in a manner consistent with state law. We have found the state purchasing director eager and ready to improve purchasing procedures so that the hospital may realize the most for the dollar spent. He has, for example, adopted a uniform set of specifications for processed foods, which require that a grade certificate from the United States Department of Agriculture be submitted along with the shipment, thus insuring that the hospital receives merchandise which meets specifications. He also set forth uniform specifications for meats and meat products and other types of food.

It is obvious that even though the hospital is paying more for the individual units of purchase than before, much is being saved by eliminating waste and by the introduction of a portion controlled program. Paints are purchased in accordance with State Highway Department specifications and subject to laboratory testing by that department. Specifications meeting the requirements of the state hospital have been written for some items of clothing, especially ladies' dresses, and contracts are being awarded to the highest bidder for these items, because tests have proven that they are the best buy.

Clothing causes many problems in most institutions. An insignificant thing like the buttons used on a garment may cost plenty in personnel time. The type of material that goes into the garment and the manner in which it is manufactured are important points to consider. If each gar-

ment requires extensive repairs such as replacing buttons and sewing up rips and tears, the low bid may ultimately cost considerably more than the high bid.

Most hospital administrators and certainly all the dietitians know that the hospital can be "skinned" by always accepting the low bid on food items. The dietitian must consider the cost of a single portion along with its quality in determining the cost of meals served. She must also consider the length of time it takes to prepare the item for the table. If Brand A tomatoes cost 10% less than Brand B, but Brand B contains 20% more individual servings, then certainly Brand B is the cheaper. The same thing applies to meats, fruits and vegetables. For example, a pound of bacon having only ten slices will serve five people if the serving is to be two slices, while a pound of bacon having sixteen slices will serve eight people. Naturally one must consider the total servings available in a given unit of purchase when comparing the cost. This isn't always done by the state purchasing director, inasmuch as he has to consider the unit, not the portion, cost.

Many states require that all drugs, except experimental ones, be purchased by generic names only. If the doctor has no confidence in the brand name purchased, and will not prescribe it for his patients, money spent for the drug is wasted. Here again the hospital has as its function the care and treatment of human beings, while the purchasing director has as his function the procurement of state agency needs at the lowest possible cost.

Maintenance supplies such as paint, lumber, plumbing and electrical supplies are available in many grades and degrees of serviceability. The cheap paint may require two coats to cover the surface, while more costly paint might cover the surface with one coat. The use of the cheaper paint will, of course, ultimately cost more. One incident regarding maintenance supplies comes to mind concerning the purchase of closet bowls for a mental hospital. The hospital had specified a certain manufacturer's item and the contract was awarded for another type. Because of the method of installation the item purchased could not be used without completely revamping the plumbing outlets in the building. Fortunately, in this case the hospital was permitted to return the toilets and purchase a type that would fit into the space provided.

Avoid Unreasonable Requests

The problems of procuring the right types of equipment and supplies are so numerous that it would be difficult to enumerate them all. Sometimes we become overzealous and inflexible in our thinking and make requests which are inconsistent with good business management. So we should be consistent and give the state purchasing director credit for trying to do a good job for the state.

One director explained some of his problems to me. He showed me purchase requests from three different state agencies, each supported by strong letters of justification in which he was requested to waive the formality of bidding and purchase a given type of floor polishing machine. Each of the agencies had requested a different type and made a strong point stating that the type desired was the best piece of equipment manufactured from the standpoint of serviceability, durability and ease of operation. One can easily understand his dilemma in trying to explain to one vendor that on the one hand his machine is the best manufactured, and on the other hand, it is the worst!

We should appreciate some of the problems of the central purchasing authority, and develop some flexibility in our dealings with him. Personal preference should certainly be considered, but one must weigh this against good public relations not only with the central purchasing authority, but with business men in the community who pay taxes to support the state-owned institution. It is reasonable to state that a good job can be done with many different makes of products. If personal preference is placed in its proper perspective, we can do a better job both for our hospital and for the state which supports it.

Much progress can be made toward minimizing the problems of procurement. Write complete specifications making sure that the specifications do not discriminate against other equal and acceptable items. If standardization is a predominant need, a letter setting forth the facts should be sent along with the purchase request document (preferably such a letter should be discussed in person with the purchasing director so that any requests made which are not consistent with the state laws may be revised). Improve working relationships with central purchasing officials by encouraging them to visit the hospital to see at first hand the problems encountered in day to day operations.

A self-appraisal of our attitudes toward central purchasing authorities will result in our being more understanding of the total purchasing problem.

No Floor is Cleaner Than the Mop Used

Sour, dirty mops have long been a bugbear to us housekeepers, but now we feel we have something better. We ran a test at Coldwater (Mich.) State Home and Training School which is proving most profitable from a financial angle as well as from the standpoint of improved employee attitudes.

We purchased 36 cellulose sponge mop heads from the Fuller Brush Company in September 1957, at a cost of $19.00 per dozen, slightly higher than the $13.00 usually paid for conventional string mops.

But our figures have proved that one cellulose mop will outwear three to four string mops. Moreover, they are much lighter to handle and will absorb eight times their weight in water. Naturally, they dry a floor much faster, besides eliminating the usual scrubbing problems of string mops. They never leave a streaky floor, never splash up the mopboards and they never leave strings to wrap around the roller of the mop wringer or the casters on furniture. But best of all, they are so easily cleaned and rinsed. Conscientious housekeepers are relieved of the tedious and time-consuming chore of washing sour and smelly string mops in order to keep them in condition to clean floors.

MARGUERITE A. COLLINS
Supervisor Housekeeper

Housekeeping Experiment Pays for Itself

By PEARL ROGERS, Supervisor of General Services
and DOYLE DUNN, Psychiatric Aide Supervisor
Arizona State Hospital, Phoenix, Arizona

EVERY SALESMAN for chemical companies and janitor supply houses sells "the best waxes and cleaners available!" The trick for housekeeping and ward personnel is to obtain a consistent result from the variety of products that may be furnished if the institution is required to accept the lowest priced item that appears to meet the State specification.

The problem for the purchasing agent is to devise a specification which suppliers can meet and against which the delivered product can be qualitatively and quantitatively analyzed. For complex reasons, chemical analysis does not prove or disprove certain things, particularly about waxes. The floor surface is the only true laboratory!

Recognizing these problems, our hospital management recently decided to make tests on waxes and cleaners and establish an "approved products" list of each. To say the least, we are pleased with the returns.

Certain standards were essential to an equitable and meaningful test. Each prospective vendor was informed of the four basic factors:

1. The intended use of each product (cleaning and waxing asphalt tile).

2. A generalized specification:

The product shall be a water emulsion wax.

When applied to the floor, wax shall have no slippery characteristics and shall provide adequate safety under foot.

This safety shall not decrease during the life of the application. In other words, after wax is used and polished it will not become slippery.

Wax should be clear in color and even if dark it must be semi-transparent. It must not darken or discolor floor.

After standing in container it must not have sediment, show separation, creaming or layering.

It must be capable of storing for at least 18 months without thickening, jelling, souring or separating.

The product must spread to an even film with no beading or ridges.

The film shall have no tackiness.

It must dry to a hard, clear, glossy finish, free of any haze.

Scuff marks shall be removable with buffing and polishing and shall leave no bright marks. There shall be reasonable resistance to rubber marks and dirt impregnation.

The dried film must be able to be damp mopped without showing a reduction in gloss, whitening, softening, dissolving or lifting of the film after 36 hours from time of application. Damp mopping is done with warm (not hot) water and a small amount of neutral cleaner.

The wax shall be removable without unusual effort with the use of a scrub-brush-equipped floor machine and a normal cleaning solution.

The wax shall not contain shellac, varnish, gums, resins, petroleum wax or latex.

3. Only products found to be acceptable would be considered for purchase after the test.

4. All future purchases of products found to be acceptable would be subject to return (without cost to the hospital) if they failed to perform as tested.

A committee was formed to judge the products. In addition to purchasing personnel, it consisted of those who would use the products; a psychiatric aide-charge, the assistant business manager, the supervisor of general services (housekeeping is in this department), the director of nursing and a supervisor of psychiatric aides, who served as chairman of the committee. The business manager gave all products an alphabetical label. Committee members were presumed to be unable to associate any tested product with a given brand-name, supplier or salesman.

The committee was given a list of the rules of the game. Two corridors of equal dimensions and having nearly identical traffic problems were selected as test sites. One corridor was completely stripped of previous wax applications and divided into eight zones. Wax-A was applied to Zone-A and so on. Thereafter, each zone received the normal cleaning and buffing routine. This consisted of regular sweeping with a dry dust mop, occasional damp mopping to remove soil, and weekly buffing with a fine steel wool pad. Each waxed area got identical treatment. One tile panel for each wax product was waxed and then subjected to spotting tests with various products to which institutional floors are normally exposed.

After the experiment the Committee selecte four of the waxes and cleaners as eligible for their approved products list.

Waxes

Perma-Shine
Hammond Soap & Chemical Co.
Breico
Arizona Janitor Supply Co.
A-Plus
Columbia Wax Co.
Super-Hilbrite
Hillyard Chemical Co.

Cleaners

4-X
Hammond Soap & Chemical Co.
Briten-All
Vestal, Inc.
Floats-Off
Holcombs
Colco
Columbia Wax Co.

The group carefully observed the wax performance during the application and cleaning processes, comparing it to the requirements listed in the general specification. At the conclusion of six weeks of regular observation, the committee made recommendations to the business manager.

A second corridor was waxed with one brand of wax, then divided into equal sections, each to be regularly cleaned with one of the neutral cleaners being tested. Again, the committee compared the cleaning effectiveness of each neutral cleaner product being tested without being able to recognize the alphabetically-designated products. Incidentally, cleaners tested were without color or scent. The cleaners were tested on walls to determine their ability to remove common dirt, lipstick smears, grease-pencil marks, and each product was tested for its ability to clean porcelain fixtures. Again, conclusions and recommendations were presented by the committee to the business manager.

While these tests were being conducted on waxes and cleaners, samples were set aside, each having a like amount of steel particles added to determine their potential for rust action. Additional samples of the products were observed to determine if they would jell, sour, separate or have an appreciable precipitation of sediment.

In addition to making written recommendations, the committee met to discuss the entire procedure and to have revealed to them the previously hidden brand names. A number of them were surprised to find that highly regarded products had been declared unacceptable; none were surprised to find that one or two old standbys were among those approved.

Vendors Told of Results

All vendors submitting samples of either product for testing were informed of the complete results. Those whose products were on the approved list were asked to place sealed bids for a full fiscal quarter's supply of each of the two products, this being the amount normally purchased and stocked in the warehouse.

This cooperative research effort was carried on simultaneously with a program in housekeeping education. This program, among other things, has taught us a new respect for the amount of each product to use. We have dropped our annual wax consumption by 450 gallons, our neutral cleaner consumption by 2,000 gallons.

Run these figures through your budget! Last year we were paying an average of $4.76 per gallon for wax; this year's price is $2.05 per gallon for a product that stood up in our blind test against waxes costing more than twice that amount. Last year we paid $2.10 per gallon for neutral cleaner. This year's protected price for a tested product is $1.30 per gallon. We expect the reduced consumption and reduced price to save us $2,988 on wax and $7,400 on neutral cleaner during the year.

The experiment and training program were carried on at a fraction of the expected savings.

Linen Control and a Wash Formula

By L. C. WAYNE, Asst. Supt., Business Services
Metropolitan State Hospital, Norwalk, Calif.

AN ADEQUATE SUPPLY of linens in a mental hospital is one of the more important aids to the Nursing Service in caring for the patient. Various systems have been tried with varying degrees of success to assure that the quantity of linen needed is on hand at the ward level.

At one time in our hospital, each ward was assigned a complement of linen. It was the responsibility of the ward personnel to see that this complement was maintained. The linen for the wards was marked with the ward identification and after laundering was returned and stored on the ward. To assure an adequate supply at all times, especially in critical areas, various subterfuges were used by ward personnel to obtain additional linen from stores. Conscientious ward personnel were generally short of linen supplies while the ward charge using subterfuge had an over-supply.

After much study, we decided to establish a central linen control and all surplus linen was removed from the wards to the central linen supply. For the first few weeks of operation, soiled linen was picked up from the wards and clean linen delivered as requested. Soon there was not sufficient linen left in the central supply to fill all of the daily orders. An investigation showed that most of the wards were hoarding. A few of the wards cooperated from the very beginning of the program and consequently were penalized because there was no linen available to deliver them. It was evident that a definite control would have to be established.

To start the control, the wards were listed under the categories of tidy and untidy, ambulatory and bedfast. An actual daily check was made to determine the usage of sheets and pillow cases, towels, tea towels, etc.

Education Resulted in Cooperation

We had little trouble establishing the daily delivery on the open wards. In the more critical areas, we were not as successful in making up a delivery schedule. The supervisors and ward personnel were helpful, however, and after six weeks, we came up with a delivery formula that we felt would be adequate.

The policy of our central linen supply established that whenever extra linen was needed day or night, the wards could request the linen through proper channels and it would be supplied. It took several months to educate all of the employees to this fact. When they realized that linen would be supplied on request, there was a great decline in the amount of linen hoarded on the wards.

The wards were requested to notify the laundry when they found they had accumulated linen over and above their daily needs. They have been faithful in doing this, and as a result the central linen supply has sufficient linen to take care of all needs.

A spot check is made from time to time throughout the hospital, and in most instances, it has been found that individual wards could be allowed a few more items on their shelves for emergency use.

We have not had to worry about segregating linen from the critical areas because our laundry has developed a system of washing "according to soil." When the laundry has a load of heavily soiled items, they wash accordingly. The wash formula that we use has been found by us and other institutions which have adopted our system to be very effective.

From time to time we take samples of the finished linen to our laboratory where it is tested and it has always been found free of any contamination. The use of this formula has insured us a cleaner, whiter wash, a reduction of decubiti and greater comfort to our bedridden patients.

WASH FORMULA FOR HEAVY SOIL

OPERATION	*WATER*	*TEMPERATURES*	*TIME*
1—Flush	10"	90	5 min.
2— "	10"	90	5 min.
3— "	10"	90	5 min.
4—Suds	5"	135	7 min.
5— "	5"	160	7 min.
6—Suds-Bleach	5"	160	7 min.
7—Hot rinse	10"	160	5 min.
8—Split rinse	10"	140	5 min.
9—Cold rinse	10"	Cold	3 min.
10— " "	10"	Cold	3 min.
11—Sour and blue	10"	Cold	5 min.

SOAP—Stock soap solution, 2 parts high teter 88% soap, and one part Sodium Sesquisilicate.

BLEACH—2 quarts of 1% bleach per 100 pounds of clothes.

Steam Tanks Prepare Garbage for Swine

Since there is a law in Idaho, and in most other states, that garbage fed to swine must be cooked, Nampa State School has devised a system for cooking garbage which minimizes handling.

After garbage containers are removed from the kitchens and dining rooms, they are taken to a "dock" where they are emptied into 1,000 gallon tanks mounted on wheels and equipped with steam flues. Each day a tank is pulled to the boiler at the slaughter house, where a steam line is connected to the flue in the tank and water is added if necessary. With 60 pounds of steam pressure in the tank, garbage is cooked "well done" in approximately four hours. It is then taken to "holding" and "cooling" tanks, emptied and fed the next day.

As a result of cooking, hogs will eat turnips, rinds, and other things they would otherwise refuse, without leaving waste materials in the feeders. And, because of cleaner conditions, there is less possibility of disease in the herd.

LAWRENCE NELSON
Farm Manager

New Foot Release Augments Laundry Safety Precautions

Even though the laundry presses used at Agnews (Calif.) State Hospital are of a late type, purchased in 1951 and equipped with two operating buttons for closing the press (these are placed in such a way as to prevent operators from getting their hands caught in the press), we had the misfortune of having three operators seriously injured within a short period of time because of safety button malfunctions.

Investigation disclosed that small particles of dirt or lint around buttons or valves would cause one button to stick in the depressed position, which would allow the press to be operated with one hand, virtually eliminating the safety factor.

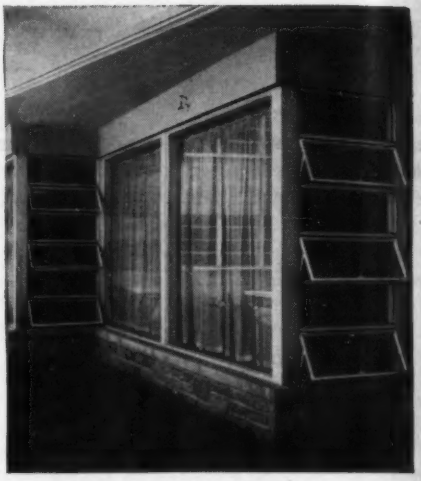
In an effort to protect employees, a daily inspection of every press is made by a qualified mechanic before the day's operation is begun. Employees are instructed to try the buttons for proper operation throughout the day and report the slightest defect immediately.

We have also added a feature which I feel is very important to the press operator: a foot-operated valve that will immediately open the press regardless of the position of the operating buttons. This does not eliminate the possibility of the operators getting their hands caught in the press but it will enable them to free themselves before receiving a disfiguring burn. The foot release is a lever operated, self-closing valve installed directly on the supply line to the main air ram cylinder. This valve must be large enough to discharge air at a greater rate than can be supplied by the main air line. This change is simple and inexpensive to install.

If one crippling accident can be prevented it will be well worth the time required to make this change.

FRANK S. BURGESS, Jr.
Chief of Institution Maint.

The detention screen, used with this Truscon Intermediate Louver Window, is the principal restriction against injury and escape. Screen can be opened only by authorized use of a removable key.



These Truscon Intermediate Louver Windows offer 50% ventilation, are particularly suited to the needs of mental hospitals. A similar design provides 100% ventilation. Ventilators operate simultaneously.

Eastern Pennsylvania Psychiatric Institute, Philadelphia, Penna.; Harbeson, Hough, Livingston & Larson and Harry Sternfeld, Architects.

TRUSCON DETENTION WINDOWS combine apartment-like beauty with complete protection and safety

It's hard to believe from the casual, inviting appearance of these handsome Truscon Intermediate Louver Windows that they provide detention. That's because they're designed to conceal or minimize any appearance of enforced restraint. At the same time they're carefully engineered to protect mental patients against self-injury and to prevent escape.

Like all Truscon Steel Detention and Psychiatric Windows, they make maximum use of large total glass and ventilating areas for abundant healing sunlight and fresh air. Yet, they provide all the necessary margins of safety.

The degree of restraint can be entirely controlled by authorized personnel who operate the windows by a small removable crank—open or close the detention screens (above left) with a removable key.

You can benefit from Truscon's extensive specialized experience in the design and construction of steel windows for safe confinement of mental patients. Simply ask your nearest Truscon® representative for technical assistance. Catalog includes complete specifications. Send coupon for free copy.

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ARCHITECTURAL
Feature
Of The Month

Architectural Research and the Construction of Mental Hospitals

By CHLOETHIEL WOODARD SMITH
Partner, Satterlee and Smith—Architects, Washington, D. C.

THERE IS A GROWING and disturbingly persistent sense of dissatisfaction with all architecture today, particularly for the new and complex field of mental health –and among architects and clients alike. There was a great post-war dream of perfection for all types of buildings. Now that our fine renderings and models have become reality, this "real" reality hasn't come up to our expectations. The older "modern" period has outlived its usefulness; its reaction against the eclecticism of the past wasn't enough to carry us through such a building boom as we have had in the last few years. It could have lived on much longer if we hadn't built so much—and for two reasons: first, fast repetition bred familiarity and its measure of contempt; second, there wasn't enough time to get acquainted. Once an architect lived intimately with each of his buildings and it was difficult for him to make so many of the same mistakes twice because he proceeded at a slower pace. But today, we are repeating mistakes a thousand times.

As we walk through and around the tremendous number of new buildings today, they don't seem to look as good as their models. And before anyone else says "the king has no clothes" we are busily trying to find him a new and better suit. The chances for a worse suit, are, however, all too good.

The rapidity with which each new form sweeps across the country is terrifying. In the hands of the mediocre, let alone the bad designer, the trend to plasticity, for instance, removes the restraint of the post and lintel. The design formula of floor, roof, column and wall or panel can be done well—very well—and its worst isn't so bad. But now that we are seeking new directions, we may well get some very bad designs –and again, these mistakes will be repeated too often.

Recently I was going over four years of architectural magazines to find material for an A.I.A. exhibit. As I raced through page after page, I found myself beginning to read titles. Why? Because everything began to look very similar, I had to retreat to the written word. That shouldn't be.

It may be that "bigness"—both in production and design of buildings—is partly at fault for a lack of richness and variety in design. But it is also the client's fault—particularly group clients. With all the pious words uttered by Building Committees, what are they really looking for? They are looking for a safe and at the same time, exciting product, as well as a "practical" design that will be published nationally. What they really want is to be *told*. They want authority with a capital A—then they aren't responsible. And what does this attitude produce? All too often it produces another building in Dallas like one in Los Angeles like one in Baltimore. As long as client and architect aren't *both* seeking creative solutions, this will continue. The creative client in the mental hospital field is most important.

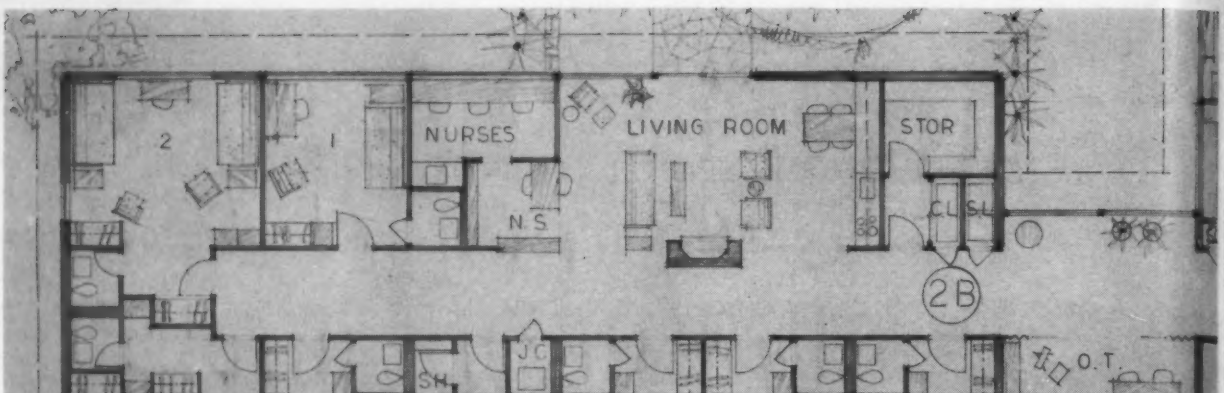
Recently I was discussing the need for research in architecture with a doctor and he said, "Why do you bother with all of that—a good architect just 'feels' a good design." Surely there is more to it than that. I believe that the more we know, the better designers we can be. No, a good architect doesn't just "feel" a design. We have been successful to a point in hiding behind that fine old business about our creative genius! But one of these days someone else is going to figure out that "knowing" as much as we can needn't hamper that still unanalyzed (and I hope it so remains) but very real ability to create.

Architects *Must* Commit Themselves

When architects and psychiatrists meet over the drawing board or on the site for a new building, immediately the need for mutual research arises. We don't expect you to tell us that you don't need to know more about human behavior—that you'll just bank on your creative genius. Yet this is what you expect of us! You retreat from our questions by saying "Nobody really knows anyhow," or "There isn't any *right* way"—and sometimes, in desperation, you end by saying that the environment has very little to do with treatment; it's people and inter-personal relationships that count! Yet how can therapy be total if it doesn't include *where* the patient is? If buildings really don't matter, then you might as well use an old barrack with a few added bathrooms—it would be cheaper and take less out of us both!

But I believe—and I think you believe too—that one of these days we're going to find some answers to the questions we ask. I hasten to add that *of course* they won't be final answers, otherwise we could build a monument and not a hospital. But they can be a lot more final than they are now!

Basically, of course, we all hate to commit ourselves. Perhaps architects are especially impatient with this



Plan of typical nursing wing designed for Chestnut Lodge shows how the corridor length is minimized by flowing into the living room and into the occupational therapy area. (The above plan is an early study drawing; modifications are being made as a result of experiments with full-scale models of the rooms.)

because, for better or worse, we have to commit ourselves a hundred times a day. We have to commit ourselves on the whole design response to your program and on every detail that goes into the building. And you—the mental hospital client—must have the courage to do the same. Until you can tell us what you want, we cannot tell you how to achieve it. We have no genius for reading your mind. We guess when we don't know—but there should be much less guessing. We need not only more knowledge of what you want, we need studies of what you now have. Such research, carried out with the same care and reported as completely as you do in many other aspects of your work, should help us to find out what you need and want.

And before we go into detail, I'd like to use the question of how to solve the corridor problem as an example of what I mean. I feel strongly about this. From the time we started the rough preliminaries on Chestnut Lodge, after it was decided that a one-story building was right for all the residential portions of the hospital, I have been beset by the subject.

If you don't want to walk through rooms, you have to go *by* them—and whatever name you gave to it, that is a corridor. And further, if you want to live on one floor and you have a lot of rooms to go by, then you have long corridors. Either put in vertical corridors (elevators), or quit howling about corridors and help think up ways to make them acceptable. It is all very like people who hate superhighways. So do I. But suggest I give up my car and ride a bus and I'll say "No". If it takes a highway to get us and our cars where we want to go, and it takes a corridor to get the people who are being treated to those who treat them or vice versa—let's come to terms with corridors.

Learn to Live with Corridors!

But the delight with which you take a simple insoluble problem and then chuckle evilly as you confront the architect—that's unfair. There are a few other insoluble problems around, and I think you could treat your architect with the same high professional standards you use in your own field. He is doing his best with a tough client. There are design modifications that he could work out with you to make the necessary evil of the corridor, for instance, more acceptable.

In trying to pull information out of a building committee, we came to the difficult subject of design—what the building should "look like". Each member of the committee has an idea—everything from a favorite house to a monastery and an Italian hill town, but not one has ever seen a mental hospital he really likes—and each doctor has seen many hospitals. In trying to go on from this unsatisfactory point, I have tried to go back to some basic questions to see if this would help. I am trying these questions on the Building Committee of Chestnut Lodge, Inc., where we are planning a new group of buildings for patients. The Committee is responding to this approach—and while we aren't finished yet, we are beginning to get some answers.

This is a reason, too, for feeling humble about architecture. I go look at a site, and in a year or so, just because I drew some lines, there is a whole group of buildings and they'll be there for a very long time. The day comes when working drawings have to be made, footings poured—and this is certainly final. Build-

Sketches and Plan of Chestnut Lodge, Rockville, Md. Courtesy of Architects: Satterlee & Smith

ings have a nasty way of outliving their builders, and a lot of building we are erecting today will be here long after the 21st century is upon us. But so will patients, and while I realize that psychiatry's "constants" are still quite few, you can even now give names to and identify quite a list of mental illnesses. More important, no matter how your concepts change, you will still be dealing with people. It may be a long time before you are confronted with any Martians who present you with new variations on life!

We started out by asking if the physical environment has anything to contribute to the treatment of mental patients apart from pure function—shelter, size, satisfaction of physical needs. The architect cannot answer this, but certain architectural studies made in recent years point the way. Essentially, an answer involves an explanation of "purposiveness" in architecture. It is increasingly possible to "condition" and "manipulate" the physical environment as one wishes. Indeed our *techniques* are getting far beyond our *purposes*. Both architects and clients fear this sudden freedom and tend to retreat to primitive forms which were developed before any of the new techniques were available. Yet inevitably the new techniques *are* used and accepted, but the fear of making the fullest conscious use of them frequently results in their misuse. It seems desirable therefore, for the client to examine the possibilities of "purposive" architecture to determine whether or not the physical environment which can be created has some contribution to make to a treatment program.

If the influence of the total physical environment on the patient is negligible, then the building should be designed as a functional element only. The architect can determine its functions by preparing a questionnaire, interviewing the staff and submitting plans for review; appearance will be determined by the client's general wishes as to what it should look like. In short, both function and appearance can be set down in a relatively simple program which makes few demands on client or architect since it ignores any really complex considerations. The right numbers of rooms of the proper size, the right placement of bathrooms, offices and so on are all familiar and relatively simple exercises.

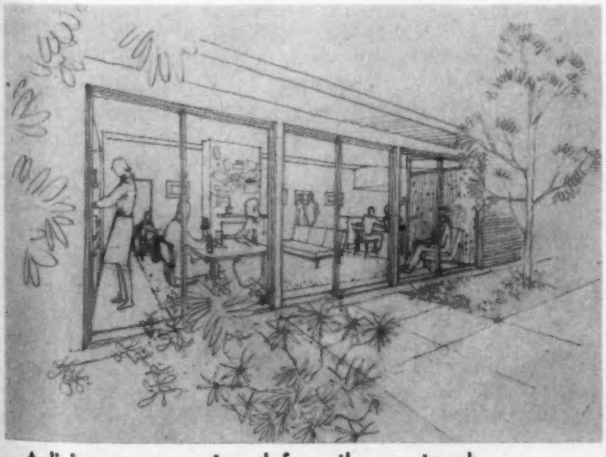
If, however, the total physical environment does or even *may* have a real contribution to make to treatment, then many questions should be asked. The fact that few questions have any *precise* answers does not invalidate the importance of asking them. There are few absolutes in any field, but the consideration of all possible benefits to be derived from all aspects of the physical environment could be an important part of research in total treatment.

The primary descriptive words used by doctors who do believe that physical environment has some importance are "homelike" and "normal". These recur so frequently that a complete analysis of what each doctor means will probably give the best picture of the physical environment he has in mind. But there is a great lack of precision in answer to the questions "What do you consider normal?" and "What do you consider homelike?"

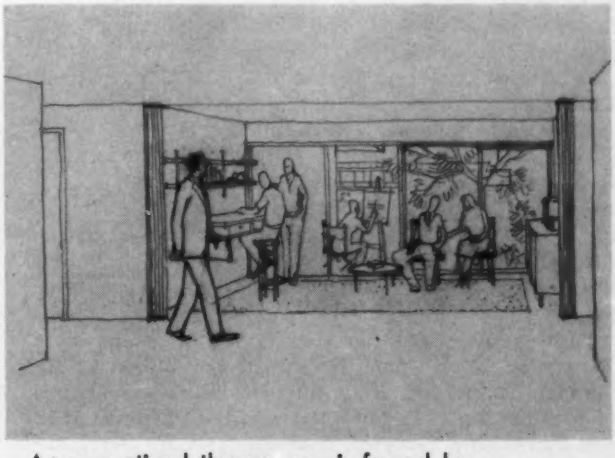
Man-made Environment Has Few Standards

There are few standards for the physical environment created by man as opposed to the natural environment, since man-made environment changes constantly. Each one who uses the word "normal" has, essentially, his own standard in mind. To some, "negative" characteristics are more "normal" than "positive" ones. Some fear a "positive" environment lest it intrude upon them. Yet every physical environment intrudes, and the extent of intrusion sensed by an individual probably has a great deal to do with his education and experience as well as with his unconscious reactions.

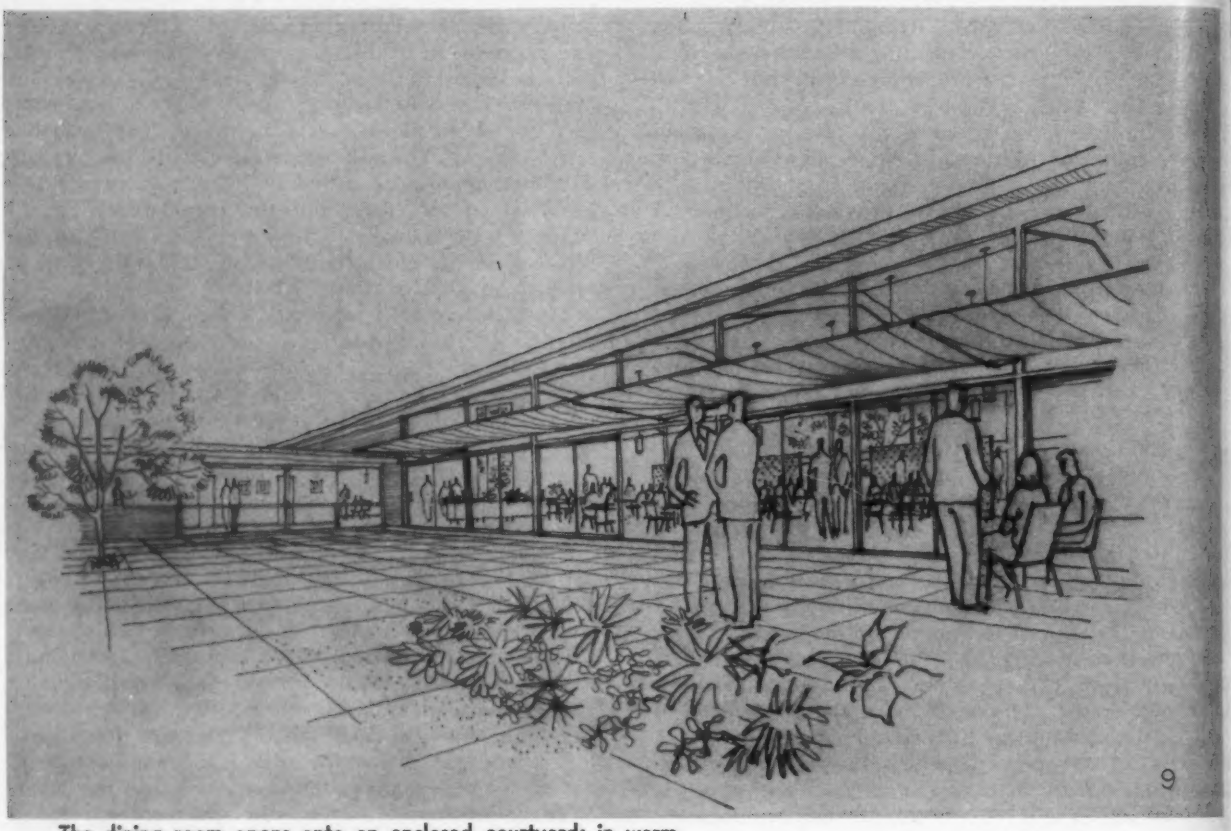
"Homelike" is even more difficult to interpret than "normal". I find this particularly difficult to understand because I do not see how any institution can be "homelike" in the sense that most authorities seem to define the word. The connotations seem impossible to achieve in any group living environment. In a home, there is security, a family, a small group where interest and love are more assured than in any other group. There



A living room as viewed from the courtyard; a free-standing fireplace separates the room from the corridor.



An occupational therapy area is formed by an alcove off the corridor at the entrance to the nursing unit.



The dining room opens onto an enclosed courtyard; in warm weather patients can dine outdoors on the terrace.

are "real" activities in contrast to a hospital where schedules are essentially arbitrary. "Getting well" doesn't have the same protective schedule as "running a house" or "returning from work" or "celebrating a holiday". Generally the permissiveness of the home is not something which has to be sought, as does the "permissive" atmosphere of a hospital.

The phrase "to reach a patient" is frequently used. Some of the examples I have read are interesting in that they show how apparently small acts or recognition of a detail that could escape any but the most sensitive staff member have contributed to "reaching" a patient. This supra-consciousness to all factors affecting the patient seems to cover everything but his physical environment. Yet one doctor, writing of its importance says "psychotherapy can be effective in a foxhole . . . (and) can be even more effective in proper surroundings." If, as he implies, the manipulation of the physical environment can speed up "reaching" a patient, surely the building and its grounds become as much a research project as all the other factors.

Possibly the reason for the recurrence of the word "homelike" arises from the use of the indestructible, low-maintenance materials and furnishings commonly used in hospitals. The hospital world is physically hard and slick—shiny, polished, *obviously* easy to keep clean —and terrifying! Never a dull finish or a soft texture. Even color seems somehow wrong. The warmth of fine materials—of wood, stone, brick, ceramics, and fabrics—is lost. Yet is consideration only of first cost really the cheapest approach? Couldn't the use of finer materials be considered an instrument of therapy? This need not imply a luxurious country-club atmosphere, but it could mean finely designed rooms, elegant in the best sense of that word.

"Style" is Not the Only Factor

We are also studying a system for changing paintings, prints, sculpture and other decorative elements as a possible solution for the single "stage set" hospital room that is always the same—each sturdy piece of furniture always put back into its "proper" place.

Some doctors have said that they want a "negative" physical environment—yet no environment can be completely negative. What some seem to mean is that they don't want a "visual" environment that is too positive, and more often than not they mean by this a "modern" interior or an insistently "glassy" exterior. Some seek a certain historic style that they may like—that they find restful or "unobtrusive". They rule out as unimportant the manipulation of the many factors in design other than "style"; not only perception in its widest meaning, but sound, light, heat, tactile sense—the entire range of man's abilities to experience the world about him. It is the manipulation of all of these factors that produces "purposive" architecture—not just "style".

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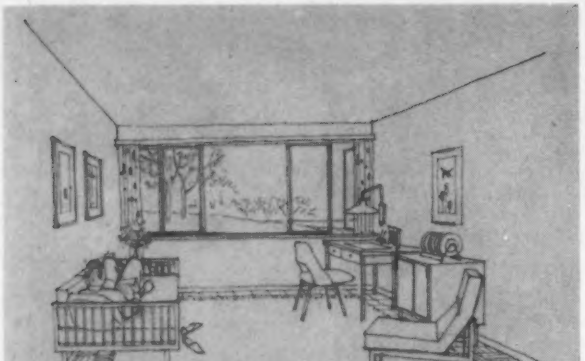

Patients' rooms are planned to be individual living spaces rather than traditional bedrooms.

The architect cannot but wonder, in view of the minute detail with which psychiatrists study the patients' interpersonal relationships, what goes on in the patients' minds and how they react to other external stimuli during the long hours when they are alone. Isn't the "positive" manipulation of all external forces, such as heat, cold, quiet, noise, odor, etc., of value, in addition to visual perception?

Wouldn't the study of rooms to create a programmed total atmosphere be valuable? For example, the changes in temperature, pulse rates and so on—are they not part of the total process? Some testing should be done to see if varying temperatures could help "reach" a patient. Should any plans be made, for instance, to meet the night time problem when the patient is alone—perhaps the loneliest time of all? At this time his "total environment" is physical; there are no people; maybe there are a hundred ways to make this time more valuable, perhaps to "reach" the patient or to prepare him for his more active relationships during the day: light that removes shadows but is like the night sky; sounds that prevent loneliness and fear but don't intrude; and if perhaps the moment of waking is a most valuable one, the space the patient wakes to—the space within and beyond the room—can intensify its value.

Do different mental illnesses have any known effect on perception, hearing and so on? We know that age makes some difference; Dr. Osmond maintains that schizophrenics have their own visual distortions. Do rooms appear very different in size, shape, etc. to different types of patients, to the old, to the young and so on? Can we find the shapes, sizes, and colors that assist treatment, instead of assuming that treatment will go on "in spite of" the environment?

The entire world of sound is part of the physical environment which can be manipulated to utilize sound or control it. This is an architectural problem in the full connotation of the word. Do the patient's own rooms need sound-conditioning even more than the common rooms? Is it possible that the "hospital feeling" of the rubber floor and sound-absorbing ceiling, nurses with rubber soles, etc., make a "sick" atmosphere which is undesirable? Perhaps daily "normal" sounds—a cock's crow, wood being sawed, rug shaken, broom sweeping, dog's bark—help to "reach" the patient, and should be consciously provided. Music too, apparently accepted as valuable in the treatment of mental illness, needs some study. Is recorded music the best? Should a room be sound-conditioned to focus, soften or direct music rather than to produce a "brilliant" room? Do patients vary greatly in their reactions to music—live or recorded? Is a background of music for doing tasks valuable or annoying to most? And are recorded voices intrusive and perhaps alarming?

All Perceptions Need Exploration

The gamut of perceptions needs exploration—light and color, memory color, form, contour, space, distance, depth, localization, size and movement. Out of such explorations could evolve an environment—a living space—more conducive to the total therapy you speak of.

Even the mundane matter of food requires study. We presume that the manner of preparation, the variety, the surroundings of the dining area and so on, all contribute to the well-being of the patients. We wonder if it is not monotonous to eat in one dining room for 365 days a year. At home there may be the breakfast in a dining room or kitchen, on a terrace, breakfast in bed, dinner in front of the fire—all part of that "normality" mentioned so nostalgically by hospital doctors.

The tactile sense has been largely ignored, yet certain textures satisfy the tactile sense without actual contact. Watch people react to texture. They go up to a wall of gold Chinese paper to touch, take a handsomely textured curtain in hand, rub their hand on the cover of a fine leather book, walk almost "feelingly" across a deep textured rug, touch a curtain almost as a child rubs the silk bound on a blanket, put their hand in a spray from a fountain, "feel" a piece of warm sculpture. Are these things to be lost in the patient's limited world or is this again part of "total therapy"?

Mention "odor" and the horrid miasma of the mental hospital back ward is evoked—largely the result of bad housekeeping and poor ventilation. This, too, is architecture's business—to build in good ventilation, to admit the fresh smell of outside and even the strong, pleasing odors of good food.

Is it true that people, even the mentally ill, are more alike than different? And if so, can we find some important characteristics of physical environment common to all mental patients? Simply because this is such a complex subject, should any factors of "total therapy" be ignored, until someone can say with authority "This won't help at all"? Today so much information is available that we tend to cut out many fields—perhaps the very ones we should explore.

Even the absence of contrast in most hospitals leads to dreadful monotony. We should study the need for contrast in the environment of different areas. A high ceilinged lounge, a dark, inner-directed reading room, and so on, might afford a desirable change from the determined "cheeriness" of bright colors in the hotel-like lounges and bedrooms we see in some recent hospitals.

What reactions do patients have to their "bedrooms" at various times of the day? Since few of your patients are physically sick, doesn't the emphasis on "beds" make an abnormal atmosphere for most patients? Does the implication of physical illness tend to increase the mental patient's sense of "sickness"? If a patient is near or in his room with a symbol of illness—a bed—does he feel worse?

Since there is such stress on interpersonal relationships in most hospitals, it is important to study group spaces and analyze the type of space that fosters relationships.

Relevant factors include the size of the seating space, the sound control, the ease of pulling up a chair to "join the group", size of table, type of lighting to foster a discussion group around a table, type of lighting conducive to quiet discussions, a round table which allows one to see others without turning, the standing space around a drinking fountain and so on. Since real separation is needed between the group areas and the private areas, perhaps we sometimes tend to overstress the "group" at all times.

And of equal importance in all of "purposive" architecture is the effect of the physical environment on the staff—how it affects their attitudes and thus their effectiveness with patients. Yet, as important as this is, most of the staff do not live 24 hours a day in the hospital. They go on to a wide range of environments and activities with other people. It is right that the stress be placed on the patients, but neither the staff nor visiting relatives and friends can be ignored because they too are affected by this world of the hospital for the illnesses of the mind.

Mock-up of Room for Study

There are thousands of questions we are asking. We are beginning to get some answers. Because it is so difficult for most people to visualize buildings and spaces, we have built at Chestnut Lodge in Rockville, Md., full scale model rooms that we are now studying. We are changing sizes, shapes, colors and furniture and then calling in doctors and nurses and patients to experience these rooms. We wish we could mock-up the whole new hospital group, but in lieu of this, we hope to keep complete records of the experiences of patients, staff and visitors to the model rooms and share the mistakes as well as any successful solutions. So much research is needed by the architects and by the clients for new mental hospitals, and this must be expanded to include better techniques for recording the experiences of using a hospital. This requires creative effort just as much as programming and design in order to provide much of the basic information that will help to establish new directions in mental hospital design.

PUBLICATIONS OF THE AMERICAN PSYCHIATRIC ASSOCIATION

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GALE H. WALKER, M. D.

Mental Hospital Service was saddened to hear of the death of one of its consultants, Dr. Gale H. Walker, on April 22. Dr. Walker, who was 52, died of a coronary occlusion at Polk, Pennsylvania. He had served at Polk State School for 21 years and had been its superintendent since 1942.

Dr. Walker was appointed to the M.H.S. Board of Consultants in October 1951, and was particularly helpful in interpreting the needs of institutions for the mentally retarded. He was a widely respected leader in the field of mental deficiency and in 1954-55 served as president of the American Association on Mental Deficiency. He was also Chairman of the A.P.A. Ad Hoc Committee on Mental Deficiency and served as a member of the Committee on Standards and Policies of Hospitals and Clinics.

Remotivation Training Teams Made Available by Grant

Through a grant from the Smith, Kline and French Foundation, it is now possible to make available special training programs in Remotivation (See MENTAL HOSPITALS, January 1958) to selected hospitals.

Present plans are to send a Remotivation Training team, consisting of a nurse and an aide from the Philadelphia State Hospital, who are experienced in Remotivation, to set up a program and teach the technique to aides in one hospital in an area, which can in turn become a training center for other hospitals in the area.

Inquiries have been received from many hospitals, but the Advisory Committee to the Smith, Kline and French Foundation Remotivation Project, under the chairmanship of Dr. Robert S. Garber, feels that arrangements are best channelled through the State Commissioners or their equivalent. Information is also being sent to other interested groups, including the National Association of Private Psychiatric Hospitals.

Other members of the Advisory Committee are Dr. Eugene Sielke, Miss Kathleen Black, Dr. Daniel Blain, Dr. Granville L. Jones, Dr. Francis J. O'Neill and Dr. Lee G. Sewall.

Any institution which does not wish to have or cannot obtain the services of a training team in the near future, may get copies of the training manual and the 16 mm film on Remotivation by writing directly to the Smith, Kline & French Foundation Remotivation Project, Box 7929, Philadelphia 1, Pa.

People & Places

HERE & THERE: **Dr. Jack A. Wolford,** Superintendent of Hastings State Hospital, Ingleside, Nebraska, will join the staff of the Western Psychiatric Institute and Clinic in Pittsburgh, Pa., on July 1. He will serve as Director of Liaison between the University of Pittsburgh and the state hospitals in Western Pennsylvania. The Hastings superintendency will be filled by **Dr. Juul C. Nielsen,** the present head of Central State Hospital, Petersburg, Virginia. . . . After spending about a year with the Southern Regional Educational Board in Atlanta, Georgia. **Dr. Wilfred Bloomberg** will move back to New England to become Commissioner of Mental Health in Connecticut. . . . The American Occupational Therapy Association announces the appointment of **Miss Irene Hollis,** O.T.R., as its first field consultant in rehabilitation. This was made possible by a grant from the Office of Vocational Rehabilitation of the U. S. Department of Health, Education and Welfare. . . . On September 1, **Dr. William Malamud,** president-elect of A.P.A., will become director of research at N.A.M.H. . . . **Dr. Bernard Saper** was appointed director of psychological services in the New York State Department of Mental Hygiene. . . . **Dr. William J. Tiffany,** a former N. Y. State Commissioner of Mental Hygiene died recently in New York City.

Certification Committee Reports on Examinations

The Committee on Certification of Mental Hospital Administrators, during its examinations in San Francisco, certified another 12 candidates by examination and 32 on credentials. Since the "grandfather clause" expires on July 1st, 1958, this will be the last group to be so certified.

Previously the Committee certified 408 on credentials—a total of 440—and 51 by examination—a total of 63. Thus 503 psychiatrists are now certified as mental hospital administrators.

If there are sufficient applicants, the Committee will hold its next examinations in Kansas City in October, just prior to the Tenth Mental Hospital Institute. Applications should be made to the Secretary, Dr. Francis J. O'Neill, State Hospital, Central Islip, New York.

SK&F Fellowship Program

The Smith Kline & French Foundation has made a $100,000 grant to the A.P.A. to continue the SK&F Fellowships in Psychiatry through 1960. The fellowships are administered by a special A.P.A. Committee headed by Dr. Kenneth E. Appel.

The Committee recently awarded ten Fellowships totaling $13,150. These are the final awards of the three-year $90,000 grant established by the Foundation in 1955 to provide a broad range of training opportunities in psychiatry.

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Foreword by **GEORGE S. STEVENSON, M.D.**, Medical Consultant, National Association for Mental Health

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1. Graffagnino, P. N., Friel, P. B. and Zeller, W. W.: Emotional disorders treated with meprobamate and promazine. Connecticut M. J. 21:1047, Dec. 1957.

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by disease

DIAGNOSIS	NO. OF PATIENTS	NO. IMPROVED
SCHIZOPHRENIA		
PARANOID	7	2
NON-PARANOID	45	34
DEPRESSION		
PSYCHOTIC†	37	25
NEUROTIC	16	10
ANXIETY STATE	9	8
CHARACTER DISORDERS	15	13
OTHERS	16	13
TOTALS	145	105

by symptom

SYMPTOM	NO. IMPROVED
SLEEP DISTURBANCES	36
ANXIETY	30
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OTHERS	11
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